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Obstetrics

Pregnancy in Women With One Kidney*

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To the obstetrician his patients' renal function is all important. If that fails disaster is near. Pregnancy may add the extra load which invites catastrophe. In pregnancy there is a greater volume of fluids and solids to be excreted and a tendency to urinary stasis due to dilatation of the ureters which predisposes to infection. Therefore a woman with only one kidney presents two problems: (a) is pregnancy permissible? (b) if she becomes pregnant may she carry on? In either case the answer will vary with the circumstances. These include the presence or absence of previous or existing urinary infection, the present state of renal functions, the reasons for removal if a nephrectomy has been done, and the general health of the patient.

Absence of one kidney is uncommon but not excessively rare. It may be detected by intravenous urography. Associated anomalies of other organs are often present. Fortune quoted by Allan[13] states that about two-thirds of the females had malformations such as bicornuate uterus or atretic vagina. Provided the solitary kidney is sound its possessor may be entirely healthy and all functions including child-bearing may be carried on smoothly. Should the one kidney be diseased it is a matter of grave concern. Of much more frequent occurrence is the removal of one of paired kidneys for one of several indications.

The combination of pregnancy and possession of only one kidney is comparatively rare. In the Winnipeg General Hospital during the five years 1947 to 1951 there were 153 nephrectomies performed of which 61 were on female patients but these were of all ages. The Central Tuberculosis Registry of Manitoba had 4,424 new discoveries of active tuberculosis in the province in the ten years, 1941 to 1950. Ninety were diagnosed as having tuberculosis of the genito-urinary tract of which twenty-nine were women. This gives some indication of the incidence of renal tuberculosis in a province of 800,000 people.

The principal indications for nephrectomy are congenital abnormalities, infection, tuberculosis, stone, tumors, innocent or malignant, and trauma.

Schmidt[1] states that the woman with one healthy kidney does not carry much greater risk than the more fortunate woman who has two kidneys, and that in her case consent to marriage and pregnancy cannot be withheld. When renal tuberculosis has been the indication for nephrectomy a reasonable time must elapse between operation and conception. Beck[2], De Lee and Greenhill[3], King [4] and Battala-Sabaté[5] state that at least three years should elapse. Dieppel[6] and Lull[10] hold that pregnancy most probably should not be allowed at all. If the remaining kidney is not in every respect normal and functionally adequate, King[4] states that contraception or sterilization is indicated. Renal tuberculosis is usually secondary to a tuberculosis focus elsewhere, consequently such a diagnosis calls for a systematic examination of the whole body. It is largely a disease of younger people and it is characteristically common. Mussey[7] found that in the Mayo Clinic it headed the list of indications for nephrectomy in the earlier years and chronic infected hydronephrosis was not far behind. L. Battala-Sabaté[5] states that the first and last trimesters of pregnancy exert the most pernicious influence on the course of renal tuberculosis which almost invariably tends to nephrectomy.

Infection, other than tuberculous, is a frequent reason for removal of a kidney. Pyelitis may go on to pyelonephritis which, if not checked, may lead to stricture of the ureter, hydronephrosis or pyonephrosis. Wharton[8] states that the pregnant woman who has had a urinary infection has twice the chance of developing an acute attack during pregnancy and in general at least fifty per cent of those who have had pyelitis in pregnancy have suffered permanent damage to the urinary organs.

Nephrectomy for urinary stone is considered by Wharton to be usually an admission of defeat and often of neglect. If the affected kidney has been inactive for some time compensatory hypertrophy may develop in the sound kidney.

Most renal tumors are malignant. The more common malignant tumors are hypernephroma, embryoma and cystic disease of the kidney. The prognosis is poor. De Lee and Greenhill[3], Matthews[9], Lull[10] consider that following nephrectomy for malignant disease pregnancy should not be allowed in any circumstances. King[4] states that at least five years should elapse. Munro Kerr[11] reports two cases of nephrectomy for hypernephroma followed by full-term pregnancy without apparent ill result. F. J. Brown[12] quotes from Kummel to the effect that four years should intervene between nephrectomy for malignancy and pregnancy.

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When trauma has been the indication for nephrectomy the remaining kidney is more likely to be healthy.

The obstetrician who undertakes the care of a pregnant woman with one kidney should be continually on guard. In taking the history, inquiry must be made regarding previous attacks of pyelitis, nephritis, scarlet fever, erysipelas or toxaemia. Hypertension even if not associated wtih protinurea must be suspect. The urine must be frequently and thoroughly analyzed. The function of the remaining kidney must be investigated at intervals using such methods as intravenous urogram, the urea clearance test, blood chemistry, the phenolsulphonphthalein test, etc. A cystoscopic examination and passage of ureteral catheters may be indicated. Consultation with urologist, internist or ophthalmologist may be in order, especially in cases that are difficult or obscure. During labour any operative procedures that might provoke shock or considerable loss of blood should be avoided. Caesarean section is preferable to a long labour terminated by high or even mid-forceps.

However there are grounds for cautious optimism. There is a large reserve of kidney tissue which has been estimated at three to six times the normal requirement. The remaining kidney may undergo compensatory hypertrophy, a process usually not complete for two years. Against infection we have the sulphonamides and the antibiotics. Today urologic diagnosis and treatment are much better than they were a generation ago. Tuberculosis of all types is on the decrease in the civilized world. Radiologic technique has improved, permitting earlier and more exact diagnosis.

Seven cases are reported, one by courtesy of Dr. C. B. Stewart, another by courtesy of Dr. A. M. Goodwin and five from the author's practice. Of these, one does not fall strictly within the category since only nephrotomy for the removal of a stone had been done during pregnancy and nephrectomy was done after another pregnancy had been terminated at three months. It is included because it calls attention to some of the problems. The indications for nephrectomy in the seven cases are: congenital abnormality, trauma, pyelonephritis, stone (2) and renal tuberculosis (2). All the patients are known to be living and six of the seven are in reasonably good health.

Case 1—A young unmarried woman had a kidney removed in 1943 because of a congenital abnormality diagnosed by Dr. C. B. Stewart as causing obstruction at the pelvic-ureteral junction leading to hydronephrosis and non-function. Later she married and in 1949 gave birth to a child. She is reported at the present time to be pregnant again.

Case 2—At the age of nineteen a teacher of dancing in fine physical condition fell from her horse and ruptured her right kidney. This was removed in 1923 by the late Dr. Jasper Halpenny. Nine years later she married and has had six children all in good health. In none of her pregnancies was there any cause for concern.

Case 3—Dr. Charles Hunter referred a patient aged 32 in her first pregnancy. She had been married for five years in the course of which weakness from anaemia and a drop in weight to 98 pounds made her seek medical attention. Calculi were found in her left kidney and this kidney was removed in 1935 by Dr. H. D. Morse and Dr. M. R. MacCharles. She then gained 20 pounds and became pregnant before the year was over, remaining well throughout her pregnancy. Four days after the expected date labour set in but when satisfactory progress was not made in trial labour a low Caesarean section was done and a healthy female child weighing 8 pounds, 3½ ounces was delivered.

Case 4—A woman of 23, far advanced in her first pregnancy was referred by Dr. A. C. Sinclair in 1949. She had developed tuberculosis while acting as housekeeper for a tuberculous patient. She spent four and a half years at Manitoba Sanatorium, Ninette, and one year at St. Boniface Sanatorium. The late Dr. A. P. MacKinnon performed a spinal fusion and six months later when she was in her eighteenth year, Dr. H. D. Morse removed her left kidney. Pneumothorax was performed two years later and she continues to have refills. On November 29, 1949, a low caesarean section was done under spinal anaesthesia and a healthy male child of 7 pounds, 9 ounces was delivered.

Case 5—A married woman of 25 presented herself in 1931 well advanced in her second pregnancy. At fifteen she had had her right kidney removed by the late Dr. Halpenny. She married at twenty and had a child in 1929. By 1931 her bladder could hold only two ounces of urine. The second child was born on December 6, 1931. In April, 1932, she complained of much pain in her back and frequency of urination and she was referred to a urologist, the late Dr. E. J. Boardman. When she became pregnant in 1934 caesarean section to be followed by sterilization was advised. On July 3, 1934, a classical section was done and a live male child delivered. The tubes were divided, tied with silk and the ends buried in stab wounds in the uterine muscle. With the perversity that sometimes waits on those most in need of sterilization, the right tube worked free and she became pregnant in January, 1935. At that time her husband and she and their three children were living on a raw farm east of Winnipeg under the farm rehabilitation scheme evolved in the height of the depression. Life was miserable for her. After consultation it was decided to terminate the pregnancy when she was

not quite three months pregnant. In attempting to remove the placenta with ring forceps omentum was brought down. Immediate laparotomy was done and a rent on the right side of the uterus was repaired. The tubes were again tied with silk and she left the hospital in May, 1935. In February, 1936, she went to the Mayo Clinic. Inoculation of a guinea pig showed that the left kidney was tuberculous. She was advised to have the left ureter transplanted into the sigmoid colon or through the skin but she declined. In July, 1936, she was found to be pregnant again and a therapeutic abortion was done. In 1945 she and her family removed to Duncan, B.C. Dr. D. S. McHaffie has kindly furnished further particulars. In 1945 he performed a therapeutic abortion, and two years later when she was again pregnant he did a subfundal hysterectomy. By January 16, 1952, she had very severe daily headaches, felt very tired, urinated 20 to 30 times during the day and 12 to 15 times during the night. Her blood pressure was 220/110, weight 120 pounds, haemoglobin 85 per cent. The urine shows trace of albumen, 2 pus cells and one red blood cell per H.P.F. What can the human frame endure!

Case 6—A professional man's wife had four children, then developed attacks of severe pain in the right loin. A calculus was removed from the pelvis of her right kidney by Dr. P. H. Thorlakson when she was six months pregnant. Seventeen months later the pain was severe and incapacitating. She was about ten weeks pregnant and a vaginal hysterotomy terminated the pregnancy. Two months later Dr. C. B. Stewart incised, drained and suspended the kidney, but in the next year he found it necessary to do a subcapsular nephrectomy. She has continued to live a busy useful life.

Case 7—A housewife from a Manitoba mining town was admitted to the Winnipeg General Hospital in her fifth pregnancy, the third since a nephrectomy performed by Dr. C. B. Stewart in 1945 for a right hydro-nephrosis resulting from pyelonephritis. Before the operation she was thin, pale and toxic. On her admission in February, 1952, she was mentally depressed and Dr. Jessie McGeachy, who made the psychiatric examination, recommended sterilization. After delivery a Pomeroy ligation of the tubes was done.

Summary

Pregnancy after nephrectomy is comparatively rare.

Normally there is a considerable reserve of kidney tissue.

After removal of one kidney compensatory hypertrophy develops in the remaining organ provided it is healthy.

Pregnancy in a woman with one sound kidney probably carries no greater risk than pregnancy in a woman with two kidneys.

During pregnancy after nephrectomy the function of the remaining kidney should be thoroughly investigated, aided when necessary by consultation. If renal insufficiency develops, pregnancy should be terminated promptly.

If the remaining kidney is not normal and functionally adequate contraception or sterilization is indicated.

Seven cases of pregnancy after nephrectomy are reported.

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The Physiology of Reproduction
The Endocrine Glands and Their Secretions

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Section "B" No. 5

The Anatomy of Uterine Muscle

Sam Kobrinsky

Histologically the uterine muscle fibres are smooth muscle, being spindle shaped cells with centrally placed nuclei: Each individual cell is approximately 50 microns in length. During pregnancy these increase in size until they reach lengths varying from 200 to 600 microns at term. The fibres of the pregnant uterus exhibit longitudinal fibrillation in their cytoplasm which is not present in the non-pregnant uterus.

The classic conception of the gross architecture of the uterine musculature is that the fibres are grouped in bundles which form three layers. An outer and inner thin layer, and a thick, vascular, middle layer. These are distinguishable only during pregnancy.

The outer layer covers the corpus uteri in a hood-like manner down to the point at which the peritoneum is loosely attached near the upper border of the lower uterine segment. This is composed of extensions of the longitudinal fibres of the uterine tubes. The fibres composing this layer do not cover the sides of the uterus but run longitudinally over its anterior and posterior surfaces, crossing the middle and interlacing with fibres from the opposite side.

The middle layer is composed of extensions of the circular fibres of the uterine tubes, and fibres radiating from the uterosacral, round and ovarian ligaments. This layer is thickened on the anterior and posterior wall of the uterus near its middle. It also contributes looped bundles of muscle around the tubal ostia, and around the internal os of the cervix. A rich plexus of blood vessels courses through this layer.

The internal layer is similar in structure to the external layer, but is more closely adherent to the middle layer than is the external.

Between the bundles of muscle and layers of the uterus there is a rich, soft, connective tissue, resembling embryonal connective tissue which permits free motion between them.

The muscle of the lower uterine segment is the same in architecture but distinctly thinner.

Another conception of the structure and arrangement of the uterine muscle bundles which is widely accepted now is that of Goerttler, a German gynecologist. In 1930 he reported a careful study he had carried out on various uteri, foetal, young adult, pregnant and non-pregnant. He used a technique that consisted, briefly of very gently separating all the muscle bundles one from the other, then spraying the specimen with fine gold particles. This was then examined under intense light and the course of the muscle bundles thus followed.

According to him the musculature of the uterus consists of two interlaced spiral systems. He also claims that this spiral arrangement is present in the Mullerian ducts of the embryo, interlacing with that on the other side when they fuse, and then growing thus through infancy, childhood, and adult life.

The arrangement of the muscle fibres in the cervix is different in its two portions. The supravaginal portion is described as having an external muscular coat only—derived from the cardinal ligaments, the uterosacral and vesico-uterine ligaments. This layer of muscle fibre runs obliquely and longitudinally on both sides of this portion of the cervix.

The portio vaginalis has an inner submucous and circular layer and an outer longitudinal layer, both derived from the vagina. These muscle layers are thin, laterally giving this part of the cervix a tendency towards the formation of anterior and posterior lips.

It must be mentioned here that Danforth has recently stated that the cervix is chiefly a fibrous organ, having very scanty, and irregularly arranged muscle fibres. Further studies will probably corroborate this, and cancel out the orthodox conception of the structure of the cervix.

Hoffner has described a special layer of muscle, lying most superficially and consisting of tissue similar to that of the Purkinje fibres in the conducting system of the heart. This has not been corroborated by other investigators.

The Lower Uterine Segment and Its Role in Labor

The lower uterine segment is derived in the main from the isthmus uteri. This is the portion of the uterus which lies between the histological internal os below and the anatomical internal os above, being from 4 to 10 mms. in length. The histological internal os lies at the point where the cervical and isthmic mucosa merge. The anatomical internal os is identified approximately externally by the point at which the attachment of the peritoneum to the uterus becomes loose, then to be reflected forward to the bladder. Internally it can be identified by an internal ridge or rounded eminence in the uterine cavity.

These ostia are inconstant, there being a mingling of cervical and isthmic glands over approximately 1 mm. The rounded eminence in the uterine cavity also is often indistinct, or incomplete.

The isthmus uteri differs from the remainder of the uterine cavity anatomically in that there are fewer glands and much thinner mucosa. It differs physiologically in that it reacts only slightly to the cyclical hormonal stimuli. It differs biochemically in that normally the isthmic glands contain no glycogen.

As pregnancy progresses the isthmus grows with the rest of the uterus to become the lower uterine segment. During the first 4 to 10 weeks it elongates 2 to 3 times. When the third month is reached the wall of the isthmus unfolds quite rapidly and the isthmic canal becomes included in the general uterine cavity.

The gross anatomical evidence of this rapid unfolding at this period of gestation lies chiefly in changes in form and growth of the uterus, there being a definite change in the breadth and thickness of the uterine cavity. There is also a greater increase in sagittal circumference of the cavity, and a rather sudden increase in the average distance of the lower edge of the placenta from the internal os of the cervix.

Throughout pregnancy the isthmus hypertrophies equally with the upper segment and reaches a length of 7 to 10 cms. at term. The anatomical relations of the lower uterine segment are as follows:

(a) **Anteriorly from below upwards**—A small portion of the supratrigonal portion of the bladder.
The uterovesical pouch.
The symphysis pubis.
The anterior abdominal wall.

(b) **Laterally**—The uterine artery and veins in the broad ligament.

(c) **Posteriorly**—The Pouch of Douglas and its contents.

While the site of firm attachment of the peritoneum to the surface of the uterus is taken to approximately indicate the upper border of the lower uterine segment it usually is actually 2 to 3 cms. above that border. Allowance should be made for this in electing the level at which to make the incision in lower segment Caesarian Section.

The Role of the Lower Uterine Segment in Labor

It must be stated at the outset that the role of the lower segment in labor is still the subject of controversy and investigation, and the following is merely a brief resume of a few of the more generally accepted ideas to date.

The most widely held conception of the role of the lower uterine segment in labor is that with succeeding contractions of the upper segment, the former relaxes, becoming elongated, and thinned out, until the foetus is expelled. Relaxation of the muscle fibres occurs in a gradual, step-like manner. They are not completely relaxed because they are able to actively resist stretching. The statement that the lower segment is stretched and thinned does not describe the change in the individual muscle fibres. The change that occurs in the lower uterine segment as a whole might be referred to as a "receptive relaxation" or "postural relaxation." These terms have been used to describe, for example, the relaxation that occurs in the fundus of the stomach and other parts of the gastro-intestinal tract when material enters. These terms describe the process as a whole but do not tell us that the muscle fibres have elongated and have become relatively fixed at an increased length under which condition they manifest the same tension or tone.

It is useful at this point briefly to review some of the characteristic phenomena relative to muscular activity in general.

1. The processes of contraction and relaxation are not instantaneous but occur gradually.

2. When contracting muscle is permitted to shorten and raise a weight the contraction is said to be isotonic, because the tension on the muscle remains constant during the process of contraction and relaxation.

3. When a muscle is acting on a weight which it cannot move, the muscle does not shorten appreciably. The tension exerted by the muscle increases to a maximum and then declines. Such a contraction is said to be isometric.

4. A contraction may be isometric for a portion of its period and isotonic during the remainder and vice-versa.

5. When a contraction occurs against a gradually increasing resistance, but still moves an object the contraction is termed auxotonic.

The contractions of the uterine musculature in labor are chiefly isometric (when the cervix is undilated) and auxotonic (when it is dilating).

Metrostasis is a term that may be used to designate a relative fixation of length of a muscle fibre, without a change in tension. However, it does not indicate whether the change in length has been shortening or lengthening. Reasoning in this way Ivy devised two terms, "brachystatic contraction" to indicate shortening with relative fixation and maintenance of the same tension. "Mecistatic contraction" is used to denote the process in which the muscle elongates and becomes relatively fixed at increased length and maintains the same tension. Thus, the muscle fibres of the upper segment manifest brachystatic contraction and of the lower mecistatic pressure remaining approximately the same during the interval between contractions.

With the onset of labor the muscle fibres of the upper uterine segment contract auxotonically until such resistance is met that appreciable shortening of the fibres does not occur. Then the contractions become isometric. Relaxation occurs,

but the muscle fibres do not return to their original length. In other words brachystasis occurs. Since as the contractions continue, it is known that the upper segment thickens as the cervix is effaced, and since intrauterine pressure between contractions returns to "normal," the brachystatic contraction of the upper segment bears a reciprocal relation to the mecistatic contraction of the lower uterine segment and cervix. That is, during the first stage of labor the upper segment retracts only to the extent that the cervix and lower segment give, or relax.

During the second stage of labor the brachystatic contraction of the upper, uterine segment becomes more and more marked as the foetus descends. After effacement and dilatation are complete mecistatic relaxation of the lower segment does not occur, but holds stationary until the upper segment expels the foetus, then the lower segment contracts to expel the hind parts of the foetus.

Where the foetal head meets with unalterable resistance due to pelvic disproportion for example, the lower uterine segment becomes excessively thinned, and the upper uterine segment excessively retracted, and the normal physiological retraction ring becomes a pathological contraction ring.

In the 3rd stage the upper segment contracts brachystatically, and the lower segment relaxes to receive the placenta.

Danforth, Ivy and associates have done some extremely interesting studies on the functional anatomy of labor in the Macacus Rhesus monkey. The animals in labor were lightly anaesthetized and the course of labor followed, by vaginal examinations. At the stage of labor desired, the animal was fastened to a rectangular frame which maintained a modified lithotomy position and at the height of a contraction the animal was thus lowered into a freezing chamber containing a mixture of 95% alcohol and chipped solid CO2, the temperature being 70 to 80 degrees. The animal was kept in the chamber until well solidified and then removed. The frame was then placed on a movable platform and the animal sectioned as desired by a motor driven saw.

Measurements of tracings and directly from these specimens form the basis of their conclusions. Among these is the observation that, contrary to general belief, the lower uterine segment does not lengthen vertically, but shortens. They put forward the opinion that the sensation of thinning of the lower uterine segment is given only by contrast with the thick upper segment.

In a further study of human pregnant uteri Ivy also holds that the lower segment shortens vertically, and also that it becomes thinner by horizontal lengthening (i.e. widening) of the middle circular layers of muscle fibres—Mecistasis.

Summary

The anatomy of the uterine musculature is reviewed briefly.

The development of the lower uterine segment from the isthmus uteri, and its growth during pregnancy are described.

The physiological role of the lower uterine segment and its relation to that of the upper segment in labor is reviewed.

Reference is made to studies of the functional anatomy of labor by Danforth, Ivy, et al.

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Clinico-Pathological Conference

Deer Lodge Hospital

Long Continued Fever

Y.O.B. 19-1-89

1935—In tuberculosis sanitorium for subsequent two years during which time he was submitted to a left-sided thoracoplasty. He was also told he had a duodenal ulcer. No barium series investigation.

Since discharge from sanitorium he did not work and was sustained on W.V.A.

11 Jan., 1950—Admitted to Deer Lodge Hospital. Complained of L.O.W. of 20 lbs. since August, 1949, and L. shoulder pain dating from a fall while clipping hedge, also in August, 1949.

In September, 1949, he recalled having had "stomach flu," with persistent watery diarrhoea for a three-week period.

On physical examination, the pertinent findings were extreme pallor, and a barely palpable spleen. Old thoracoplasty on left involving upper seven ribs. Only adventitious signs were fine inspiratory and post-tussic rales in L. anterior axillary line. BP 100/65.

RBC 3.0 million cells/cumm. Hgb 37%; WBC 6,800 cells/cumm. B.S.R. 32 mm.

Neutros 86%; Lymphs 13%; Monos 1%.

Urinalysis—normal findings.

Chest x-rays and planograph studies demonstrated no changes suggestive of active tuberculosis.

Investigation as to the cause of the anemia in succeeding weeks was intensive.

Barium series; Barium enema; I.V.P., Bone films, Stools for occult blood on two occasions with three examined specimens each time, many sputum smears and cultures for T.B., and so on, were all negative and non-contributory to diagnosis.

24 March, 1950—Hgb had risen to 87%; B.S.R. down to 12mm. Anemia had appeared due to chronic blood loss and on iron alone Hgb had risen to the above level. No bleeding site had been discovered. In order to complete an otherwise quite exhaustive investigation he was sigmoidoscoped just prior to contemplated discharge from hospital. A large rectal polyp at five inches was seen, above which was noted an area partially obscured by blood and what appeared to be ulcerated mucosa. Histologic examination of the biopsy reported Adenocarcinoma Grade I.

17 April, 1950 — Abdomino-perineal resection. There was no evidence of metastatic involvement of lymph nodes or liver. Convalescence was satisfactory but the temperature continued to range between 98° and 102°.

Repeated gastric washes, sputum smears and cultures and G.P.I. were negative for acid fast bacilli. Blood cultures were negative. Urine, stool cultures were negative. No stool parasites. Agglutinations for typhoid, the paratyphoids, and brucella were negative or of normal titer.

The problem resolved itself in succeeding months into one of pyrexia of unexplained origin.

He had intermittent bouts of diarrhoea, watery in character, without blood or mucous, and unattended by abdominal pain or tenesmus.

27 September, 1950—The B.S.R. had risen to stabilize around 100mm. in the hour since July. Hgb dropped to remain around 60%. No significant alteration in W.B.C. or differential.

Recheck physical examination divulged nothing diagnostic. Liver and spleen were not considered enlarged. Gastro-enterologist ventured opinion: "I cannot explain the fever—but I think whatever causes the clostomy overactivity also causes the fever, and so far there is no discernible organic lesion. He is very tense despite his conviction that he is placid. Impression: Possibly a neurogenic intestinal hypermotility."

Further L.O.W. of 6 lbs. in past month.

The usual antibiotics did not influence the temperature.

20 November, 1950—Chest x-rays at monthly intervals up to this date (the last reported) showed no change. Troublesome night cough with moderate amount of sputum (but really a chronic affair and nothing new).

8 December, 1950—Progress note records enlarged spleen, but degree of enlargement is not available from history as recorded.

Further stools for occult blood were negative, urinalysis normal, serum biochemistry essentially normal. Hgb drop to around 49%; raised to 68% by blood transfusions.

L.O.W.—extreme asthenia, and periodic pyrexia continued.

Possibilities, all recognized to be without concrete foundation in this case, were: Carcinomatosis, amyloid disease, subdiaphragmatic abscess, Addison's disease and tuberculous enteritis.

25 December, 1950—Died. Entire course was one of steady deterioration with no outstanding landmarks subsequent to abdomino-perineal resection.

The above resume of the recorded facts has necessarily been much abbreviated due to the great accumulation of laboratory results which it is felt, do not merit inclusion and thereby prolongation of this precis.

Gross Autopsy Findings

The right lung showed early terminal patchy bronchopneumonic consolidation at the base. The rest of the lung showed compensatory emphysema being quite voluminous and pillowy.

The left pleural space was obliterated by very dense adhesions. The left lung showed gross bronchiectasis and patchy bronchopneumonia in places. No acid fast bacilli found in smears or culture.

A solitary lymph node measuring 2 x 1 cm in dimensions was seen immediately substernally. Cut section had a fish-flesh homogeneous appearance.

The colostomy appeared in good functioning order. The stomach and gastro-intestinal tract were explored throughout. The small bowel along the greater part of its course showed a non-specific reddening and congestion. There was no evidence of ulceration or hypertrophy of mucosa.

The pelvis was devoid of pathology and there was no sign of tumor recurrence anywhere.

The para-aortic lymph nodes were matted together to form a large retroperitoneal mass extending along the whole course of the chain. The consistency and general appearance of the mass was that of fish-flesh.

The liver appeared grossly normal and was of normal size and weight.

The spleen was not enlarged, weighed 190 gms, and showed two areas of old fibrosed infarction.

The histology of the lymph nodes showed lymphogranulomatosis, the lymphoid structure being entirely obliterated by infiltration of reticulo-endothelial type cells and lymphocytes with many Reed-Sternberg giant cells.

The spleen and liver did not show Hodgkin's type infiltration.

Autopsy Diagnosis

Lymphogranulomatosis (Hodgkin's Disease) Granuloma Type.

Bronchiectasis—left lung.

Terminal bronchopneumonia.

The Regulation of Body Temperature

A Review With Emphasis on the Varied Etiology of Obscure Fever

Fevers of short duration are so common and so numerous that it is impractical to even cite all of the major causes. Indeed, very little value would accrue in so doing because most of them are common infectious disorders which are readily diagnosed or which at least, by their prompt recovery, offer little hazard to re-established health even though the cause remains obscure. It is pyrexia, prolonged or recurrent over ten days which interests us: the diagnostic dilemma we label in desperation "P.U.O., pyrexia of unknown origin, cryptogenic fever or habitual hyperthermia."

Generally speaking, fever occurs as a result of imbalance of the heat-producing and heat-eliminating mechanisms of the body. The temperature of the human body, in health, remains remarkably constant under conditions of extremely varying heat production and heat loss. Recorded extremes of body temperature range from a fall to 75.2° F. to a rise to more than 113° without fatal effects. Fever occurs only if the increase in heat production or diminution in heat loss exceeds the capacity of compensation. This break in compensation may be caused by a number of different pyretic agencies, the most important being the bacterial products of infectious fevers. These disturb the hypothalamic heat regulating centres, chiefly to diminish heat loss but partly to increase heat production.

The physical regulation of body temperature is concerned with avenues of heat loss. These include:

1. Radiation, convection and conduction.
2. Evaporation of waste from lungs and skin.
3. Warming of inspired air.
4. Liberation of CO_2 from solution in the blood into the gaseous state in the lungs.
5. Excreta.

An ordinary room temperature heat loss through evaporation from the skin and lungs amounts to about 25% of the total heat loss. However, heat loss by radiation, conduction, and convection ceases when the environmental temperature rises above body temperature, and in such cases vaporization accounts for almost the entire heat loss. The other three avenues combined total less than 10%. The rate of heat loss by conduction varies with the amount of fatty tissue insulation.

The chemical regulation of body temperature is concerned with heat production by means of increased metabolism.

The hypothalamus functions as a physiological thermostat.

Artificial fever (hyperthermia) may be induced actively or passively. Active fever may be induced by injection of foreign proteins, malarial parasites, typhoid vaccine, or some colloidal substances. Passive fever, in which the body does not make any effort to raise its own temperature can be brought about by hot baths, diathermy, and various types of heat cabinets.

Although frequently the herald of serious disease, there is every indication that fever is an important aid to the body in its combat with the disease. The definite role played is unknown but it has been suggested that the elaboration of anti

bodies can be accomplished only at higher temperatures.

Moderate rises of temperature are produced in the young by minor disturbances and are less important than in adults. The temperature in infants is irregular at first, but periodicity gradually sets in with the development of regular periods of activity and rest. For example, a fit of screaming may cause a significant temperature rise while a cold bath may lower the temperature by as much as 7° F.

After childhood the vast majority of fevers are due to:

1. Infectious disease or inflammation.
2. Toxemia without infection, e.g., cancer of liver, necrosis, surgical aseptic fever.
3. Disturbance of heat regulation, e.g., sunstroke, cerebral hemorrhage or other cranial accident or coma from any cause.
4. Hemorrhage often causes a moderate rise of temperature, the cause of which is not clear. Fever of dehydration is not uncommon also.

A fever which disappears suddenly and permanently is said to end by crisis, while one which gradually passes off in the course of several days ends by lysis.

The normal range of human body temperature registered by oral thermometers is from 96.7° to 99° F. with an average of 98.6° F. Certain activities affect the registration of temperature, for instance, hot drinks, smoking and activity of the muscles of mastication cause a transitory elevation while cold drinks may result in a lowering which may require 15-30 minutes to return to normal.

Approximately 1,000 clinical thermometers were collected by the Food and Drug administration throughout the United States in the Spring of 1940. Of these thermometers about 800 were found to meet the requirements and tests specified for clinical thermometers in the Bureau of Standards. When such a considerable manufacturing inaccuracy is apparent it points out the additive total inaccuracy of one reading when there is included the frequent habit of "quick" estimations. In this study thermometers marked with specific time designations "minute," "½ minute," "60 seconds," were found to require about the same length of time for the instrument to reach equilibrium as thermometers with no time designations. Three minutes should be the minimum time interval for an oral thermometer to reach equilibrium under ordinary conditions of use.

Certain characteristic temperature patterns develop from daily charting: the staircase pattern and plateau curve of typhoid; the Pel-Ebstein type of Hodgkin's (regularly recurrent pyrexia with apyrexial intervals); the twenty-one day fever curve of flu'; the continued fever of pneumonia and tuberculosis in which the temperature does not return to normal at any period during the 24 hours; the intermittent, hectic, or septic fever in which the temperature drops to a normal or subnormal level once or more in 24 hours as in tertian malaria and septicemias; or the relapsing, remittent type of fever in which the intervals are of days or weeks as in brucellosis, lymphoblastoma and relapsing fever.

The value of temperature records, when accurate, is often obvious both in a diagnostic and in a prognostic sense. Thus the height of temperature often affords a clue to diagnosis; if over 101° F. appendicitis is a secondary guess in differential diagnosis; if under 102° F. acute lobar pneumonia might often be excluded, and so on. A sudden change in temperature may forecast some complication as for example perforation in a case of typhoid fever where such a catastrophe is evidenced by an initial fall followed by a temperature rise. The relatively low fevers aroused by infection in old people must not be forgotten.

The associated systemic effects of heat are often profound, whether environmental, infectious, metabolic or toxic in etiology. There is usually a moderate leucocytosis with increase in the rate of locomotion of leucocytes. The heart rate is increased, and it is known that the pulse rate rises more or less proportionately to the rise in body temperature in ratio of about 10 beats for each degree Fahrenheit increase. The ability to withstand high environmental temperature is a good index of a properly functioning cardiovascular system. Heat usually lowers the blood pressure, cold raises it. The respiratory rate is increased and metabolic functions are accelerated.

The practical antipyretics become such only when the temperature is excessive. It is difficult to depress the temperature materially below the normal. The chemical antipyretics, antipyrine, acetanilid, phenacetin, quinine, salicylates, etc., increase heat dissipation chiefly by mobilizing water, diluting the blood and thus promoting perspiration aided by dilatation of the cutaneous vessels. Their action is mainly central. The nitrites dilate the skin vessels directly. Aconite and veratrum lessen heat production probably by slowing the circulation.

Some Causes of Prolonged Pyrexia (After French)

1. More or less specific fevers:

Typhoid and paratyphoid. Mediterranean or Malta Fever. Influenza. Brucellosis. Spirochaetosis icterohemorrhagica. Tetanus. Typhus. Secondary lues. Psittacosis. Tularemia.

2. Localized Pus:

Prostatic abscess. Ischiorectal abscess. Pyosalpinx. Tonsillar abscess. Otitis Media. Sinus empyema. Dental abscess. Subphrenic Bronchiectasis.

Perinephric abscess. Appendicular abscess. Diverticulitis abscess. Actinomycosis. Carbuncle. Suppurating lymph nodes. Breast abscess. Parotid abscess. Empyema thoracis. Liver abscess. Psoas abscess.

3. Localized Purulent or Analagous Infections without pus collection:

Coli bacilluria. Cholecystitis and cholelithiasis. Bronchopneumonia. Ulcerative Colitis. Erysipelas. Cystitis. Inflamed hemorrhoids. Parametritis. Pancreatitis.

4. Pleurisy with Effusion.

5. Infective endocarditis.

6. Tuberculosis.

7. Non-Purulent Hepatic Affections—e.g.: Cirrhosis and secondary carcinoma of liver.

8. Gout—(in the past often diagnosed suppurative arthritis because of prolonged pyrexia).

9. Rheumatoid arthritis.

10. Blood Disease:

Pernicious anemia. The Leukemias. Lymphadenoma. Splenic Anemia. Bantis' disease.

11. Tropical Diseases:

Malaria. Trypanosomiasis. Kala-azar. Dysentery. Cholera. Oroya fever. Plague. Relapsing fever. Sprue. Tick fever. Tsutsugamushi fever.

12. Meningeal Hemorrhage.

13. Pemphigus and allied bullous dermatoses.

14. Trench fever.

15. The persistent slight pyrexias of children.

16. Functional pyrexia.

17. Fictitious pyrexia produced by malingerers.

It is wise to suspect the commonest sites of infection to be the likeliest. Tropical causes of recurrent or continued pyrexia will be suggested by the geographical details of the history. Certain conditions, on the basis of individual experience always single out in any differential discussion on pyrexias of undetermined etiology. Thus bronchiectasis may be responsible for quite prolonged periods of pyrexia with afebrile intervals of varying length. The pyrexial bouts are due either to invasion of the pus containing cavities by fresh organisms, or to recrudescence in the activities of the germs already present.

Periosteal or intramedullary abscesses must be remembered, as must pediculosis of the scalp with suppurating glands draining the affected areas.

Hypernephroma is a well-known cause of P.U.O., cardiac failure often also, probably due to retention of heat because of retarded blood flow and diminished dispersal of heat.

Investigation of P.U.O. must often be extensive. Serum tests for typhoid and the paratyphoids are utilized. Polymorphonuclear leucocytosis may point to the existence of unsuspected pus, to the exclusion of typhoid fever or malaria, in both of which there is leucopenia, or at least no leucocytosis.

Bacterial swabbings from any and all orifices, animal inoculation, sputum examination, urine and stool cultures, C.S.F. testing, x-rays of chest and teeth, examination of tonsils and other suspected foci, and so on, may be required.

The investigation of a case of prolonged pyrexia may tax to the utmost the diagnostic prowess of the physician.

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Some Observations on Infants' Feeding and Development in Swan Valley Area

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An Introduction

The subject under study is to review the data concerning the growth and development of infants in the Swan Valley area, to discuss some factors related to their health and mention others, which should they be introduced or extended might improve the situation.

The factors influencing infant growth may be divided into 3 groups:

(a) One group directly responsible for infants structure and functioning—through their specific genotype inherited from their parents.

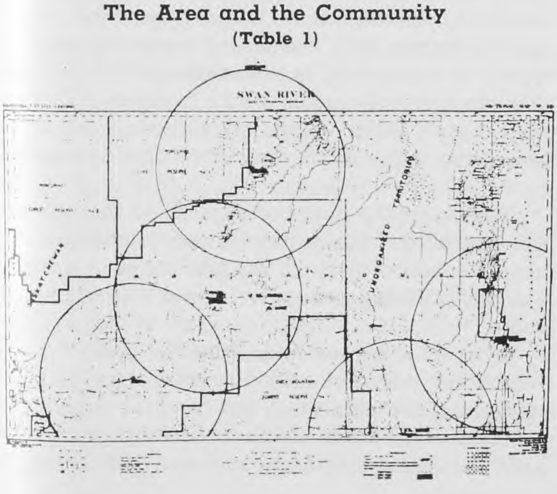
(b) Second group includes factors permanently existing in infants' environment as a result of regional, climatic and geographic conditions.

(c) The third group consists of factors influencing infants' everyday physiological requirements—sudden change of which may produce the most detrimental effect on the health of infants.

Balancing the influence of heredity and environment, Dr. J. A. Fraser Roberts is of the opinion that physical traits, intelligence and psychoses are linked rather with heredity, when general health, emotions and neuroses are influenced by the environment. Therefore for the physician dealing for instance with the underdeveloped or otherwise abnormal infant, the problems of heredity and environment are of no less concern, than those of hygiene and disease. In respect to the environment McIver thinks that the urban and rural environments have the most contrasting influence on the child's physical and mental set up. The National Health Survey of the Southern States showed that the rate per 1,000 population under 15 years of age disabling illnesses and communicable diseases was 61 to 90 for urban population and 42 for farm population.

The Area and the Community

(Table 1)



The geographic, climatic and demographic factors of the Swan Valley area seem to be so different from any other place, but so uniform on the spot, that I am under the impression that there is hardly any other area in the province, so self-contained and so homogeneous unique, in spite of its heterogeneous population.

The area of this Unit covers approximately three thousand square miles of organized territory servicing 12,500 population and 4,000 square miles of unorganized territory with 5,500 population.

The organized area centred around Swan River represents a beautiful agricultural district surrounded by Porcupine Mountains on the North and West, and the Duck Mountain on the South. As Meredith's findings confirm the opinion that the race, region and socio-economic elements have definite influence on a baby's growth and development, it is of interest to know that the inhabitants of this Valley are a mixture of 16 different nationalities of European descent and about ten per cent Metis. The Anglo-Saxon element predominates, particularly in the towns. In that area there are 2,500 school children attending 60 schools, 2 hospitals, 6 doctors and one Health Unit with 2 sub-stations.

The unorganized area of the Mountain contains 2 parts:

(a) Northern with 2,500 population, 11 schools, 400 school children, 1 hospital and 1 doctor.

(b) Southern part with 3,000 population, 19 schools, 600 school children—without a hospital or a doctor within 40-50 miles radius.

Prenatal Examination

As R. H. Ellis states that baby's birth is only one mile-stone on its journey from the uterus to the grave and its intra-uterus life lays the foundation for his post-natal health—let us review the interest Swan Valley mothers are taking to secure during their pregnancies, the optimal health for their infants, when they are still in their wombs. On the whole 135 mothers were interviewed or 85% of those who delivered their babies within the last four months of 1950 and the information obtained may be summarized as presented in table II.

SURVEY OF THE PRENATAL CARE WITH RESPECT TO THE PREGNANT WOMEN WHO DELIVERED THEIR BABIES DURING SEP. 1 TO DEC. 31, 1950
SWAN VALLEY HEALTH UNIT AREA

	Locality	Total	Distance to Doctor or Hospital	How many times was woman examined 1-3	4-6	7-9	WR	BP	Urine	Weight	HB	Diet Exc.	Good	Fair	Poor	Delivery Hospital	Home	History of Abortion	St. Bi.	Single Mothers	No Prenatal Examination
Organized	Swan River	28	up to 20 m.	22	46	105	5	24	23	22	20	1	17	8	2	22	—	5 (2)	2	1	3
	Benito Durban Kenville	14	[illegible]	2	21	45	9	12	12	12	13	1	5	7	1	14	—	—	—	—	1
	Minitonas	22	up to 22 m.	18	39	68	7	21	20	17	14	1	11	8	2	21	1	—	2	—	1
	Bowsman	11	up to 15 m.	8	23	38	1	10	9	9	5	—	5	6	-	11	—	2 (1)	—	—	—
	Total	75	- -	50	129	256	22	67	64	60	52	3	38	29	5	74	1	7 (3)	4	1	5
Unorganized	Black River to Mafeking	22	up to 30 m.	16	38	65	2	19	17	20	13	—	14	6	2	20	2	3	4	1	2
	Rest of Mountain Area North	7	[illegible]	-	-	-	—	—	—	—	—	—	—	—	7	5	2	—	-	3	7
	Cowan to Pine River	14	[illegible]	9	15	22	2	11	11	11	10	1	6	5	2	8	6	1	2	1	1
	Rest of Mountain Area South	17	up to 55 m.	2	3	8	1	3	2	2	1	—	3	8	6	8	9	1	2	3	13
	Unor. Total	60		27	56	95						1	23	19	17	41	19	5	8	8	23
	Grand Total	135	—	77	185	351	27	100	94	93	76	4	61	48	22	115	20	10	12	9	28

The prevailing size of the family is the one which has up to three children amounting in this survey to 91 families (67.4%) having altogether 156 children. The remaining 44 families have 272 children representing (63.5%) of the babies concerned. There were only 3 families with 8 children each, two with ten children each, one with 12 children and one with 17 children.

In organized territories, 70 out of 75 mothers (93.3%) have 435 prenatal medical examinations which means 6.2 examinations done by the physician for each pregnant woman. Furthermore —74 out of 75 women (99%) delivered their babies in the hospital.

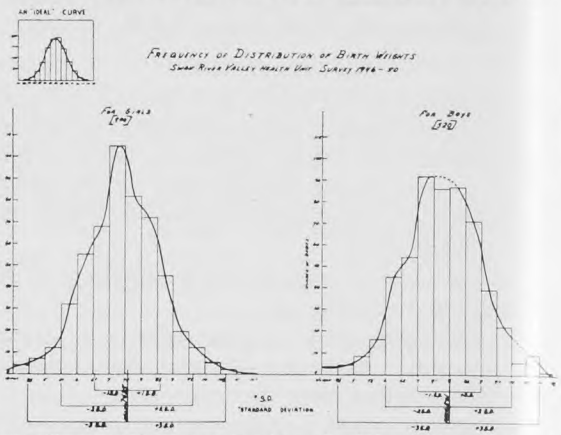
In an unorganized territory, amongst 60 only 47 pregnant women living within 30 miles radius of the hospital had their prenatal examinations done and were confined in the hospital. The rest, namely: 23 cases (38%) did not have any prenatal care and 20 mothers (33%) delivered their babies at home with a lay-woman in attendance. These figures deal only with the four-month period of the year. The correct data for the whole year for this area would be approximately 60 deliveries at home with a lay-woman in attendance. Under these circumstances one should not be surprised to notice two cases of maternal deaths in 1950 and three in 1949 which represents a very high maternal mortality rate, namely: 4.9 and 6.6 respectively, which for the province is only 0.9 (for 1950).

At the same time the infant mortality rate, although now much lower than five years ago, still indicates a high figure for 1950, namely 42.4 for the whole area and 59.8 for the unorganized territory. The majority of cases were affected with diarrhoea and bronchopneumonia. In those remote areas physicians' services are not available because of the long distances, lack of highways and poverty of the people.

Babies' Birth Weights

The precise recording of the baby's birth weight is important not only retrospectively to his prenatal history but also as a generally accepted basic comparative measurement for his postnatal progress. To answer the question how is the baby doing or progressing since his birth, one must consider not only his parents' history, antenatal care, the environmental factors, type of feeding, but also his birth weight, which may be looked upon as his starting nutritional status at the time of his birth. Here again the data available for 1,060 babies from the organized territory of Swan Valley area shows interesting frequency of distribution of the birth weights.

We see that with baby boys (table III) the greatest frequency of their birth weights is between 7 and 9 pounds, and with baby girls (table III) the greatest frequency of birth weights is between 6 and 9 pounds. This is of course only an immediate impression by taking a glance at these tables. But what would be the statistical comment



and its practical implications? Of particular interest is the average birth weight for the area and whether it is comparable with other accepted averages.

The enclosed histograms and corresponding curves which represent frequency of distribution of birth weights for boys and girls, follow approximately the pattern of an ideal theoretical curve.

In our example, the symmetry around the central figures is marked with some preponderance to the higher birth weights than 7½ or even 8 pounds for the boys. The maximum point on the curve (or mode value) describes indeed a measurement which occurs most frequently and which corresponds to the median or central value of this series of observations. A similar observation and one closer to the ideal curve pertains to the baby girls' birth weights.

Let us finally see how many observations lie within the definite time the standard deviation from the mean. The mean or arithmetic average calculated for baby girls is 7.625 pounds, and for the boys 8.01 pounds. The standard deviation or scatter around the mean is 1.125 and 1.0 respectively for girls and boys. From that we may easily calculate and see that within one time S.D. is approximately 68% values of birth weights, and within 2 times S.D. is approximately 95% values of birth weights, and is within 3 times S.D. is approximately 99% values of weights, and if not, how great is the divergence from this hypothetical curve.

The closer the data corresponds to these figures, the nearer the ideal distribution is reached. We must remember that we are dealing with a limited number of living beings and some bias is unavoidable.

In conclusion one must consider babies' weight —or other data not only the way they fit within statistical averages, but the way in which they compare with other children of the same geographic, demographic, genetic, and environmental

backgrounds. A majority of Swan Valley babies show significant advancement which is already indicated on the curve of their birth weights.

Methods of Feeding and Babies' Progress

The enquiry regarding the methods of feeding shows that among 135 babies, only 74 (54.8%) were put on the breast milk but only for a very short period of time. Only 34 babies continued on breast milk for over three months (25.2%) and only 27 (20%) for the full six months. The remaining 61 babies have been artificially fed.

This extremely low incidence of the breast feeding in Swan Valley area is confirmed also by the survey of 1,225 babies' records for the past five years—(1946-1950). The available data show that during that time among 624 baby boys, only 188 (30.1%) and among 601 baby girls only 185 (30.8%) completed their first month of breast feeding. This represents only 373 (30.7%) of the total. Practically the same number of babies, namely 371 (30.5%) were put on carnation milk, 254 babies (20.9%) were on cow's milk, 153 babies (12.6%) were put on other brands of milk, and 74 (6.1%) on mixed feedings.

The babies progress in Swan Valley Area, on different types of feedings shows that on breast milk they double their weight from three to six months and triple their weight from 9 to 12 months. The same pattern of gaining weight, is observed on cow's milk feeding. Complementary feedings boost babies' weight, which for boys at their first birthday according to Swan Valley records is between 23 to 28 pounds, and for girls of the same age between 20 to 25 pounds. The increase of weight was even more rapid when babies were put on carnation milk and the figures for baby girls' weight at their first birthday were between 22 and 30 pounds. In many instances, this rapid increase in weight should be accepted very critically, and sometimes as an example of over-feeding, which cannot be regarded as a beneficial gain of weight.

However, we do not know yet the normal pattern for growth and development and one is inclined to agree with Clement A. Smith of Boston, who states: "Everyone knows that infants do grow and develop, but few have been brave enough to set the bounds of what is normal." Accepted averages should refer only to similar conditions and factors which are changing almost during each decade. This is so well demonstrated in Meredith's findings concerning growths and development during the adolescence.

The report "Maternity in Great Britain" in 1948, states that 87% of mothers who were delivered in hospital and 85% of those who were delivered at home, have established lactation, and at six months the average figure for breast feeding was still 32.2%. In the City of Birmingham, England, human pasteurized milk is available to babies in hospitals and at home, with the priority being given to premature and acutely ill babies.

This establishment of breast feeding on a National Scale is probably the best explanation for the successful British achievement in reducing Neonatal and Infant Mortality Rates—to the lowest figures—in spite of the conditions of war and severe post war hardship.

The advisability of breast feeding and advantages of breast milk were recommended in the conclusion of the survey done in the United States under the chairmanship of C. Anderson Aldrich, Rochester, Minn., and by Philip C. Jeans of Iowa (1950). The latter one stated:

"Despite all our modern knowledge of infant nutrition and all the current refinements of artificial feeding, feeding at the breast of the mother remains an ideal procedure."

Also research work done in Great Britain by N. Robinson (1950) with respect to infant mortality and morbidity; and by Charlotte Naish on successful breast feeding (1951) support American reports that natural feedings is in many respects superior to any artificial one.

Should the mother, her physician, obstetrician, pediatrician and the nurse—all be concerned about breast feeding and to what extent? The practice shows that the great majority of infants (sometimes 99%) do extremely well on the breast milk, which should be regarded as the safest, cheapest and the most suitable food for babies.

The reasons given by 82 mothers (out of 135) for not breast feeding may be summarized as follows:

39 cases did not have enough milk (but without proving by the test feeding), 16 cases did not try, 9 cases babies not satisfied, 8 cases not allowed to nurse, 5 cases disease of breast and general ill health, 2 cases unable to nurse, 1 case did not wish to nurse, 1 case twin babies, 1 case not gaining weight.

The high number of reasons given by mothers as an excuse for not breast feeding are neither excusable nor justifiable. One may assume that mothers were not sufficiently concerned and convinced about the importance of breast feeding. The switch off from the breast feeding to the bottle feeding in the majority of cases—for no obvious reason—seems to be very striking throughout the Swan Valley area. Even such conditions as inverted and cracked nipples and breast abscesses may be prevented through proper antenatal care and necessary education of the pregnant woman in respect to hygiene of her breast. Sir Cecil Wakeley advises "that School Medical Officers should examine the nipples of girls before they leave school."

Therefore primipara mothers should have greater opportunity to secure their mother-craft lessons and be prepared for the fact that they

may at first have a poor supply of milk. This will prevent them from being upset when the test feeding shows that they do not have a sufficient amount of milk and the necessity for the complementary feeding until greater flow of milk is established.

Breast feeding is the only natural way to nourish a baby and therefore cannot even be compared with artificial feedings, since a different quality of milk is involved, a different technique for its preparation, and a different technique of feeding. During breast feeding the infant feels a continuation with his mother and psychologically is more contented and protected from the effect of deprivation.

According to Anna Freud and others, "it is an established fact in modern child psychology, that infants make their first emotional contact with the people who feed them—and for the infant, who is breast fed by the mother, food and the mother are truly identical."

The double gratification of feeding, the enjoyment of suckling and the emotional satisfaction may be fully cultivated only in the case of breast feeding, when the fullest physical and emotional co-operation between the mother and the baby are involved and secured.

Tentative Suggestions

The review of the interest in breast feeding amongst 135 mothers shows that they are lacking an awareness of the importance of breast feeding. Therefore, it is suggested that mother-craft instructions should be given during pre-natal examinations, and the hospital concerned should have at least one nurse consulting in breast feeding, besides its medical consulting staff. This nurse should see through the co-operation with the Public Health Nurse that the breast feeding is established during lying-in period and is continued after the mothers are discharged from the hospital. Each case of failure in breast feeding should be a matter of concern to the family physician and a problem for the investigation of the public health agency.

The progress of the newborn baby should be checked up not only through the physical measurements, which should be periodically recorded on baby's health card, but also through watching and recording physiological and psychological changes taking place gradually within baby's body and mind.

That stress should be placed more on the normal than abnormal, more observations and data should be collected concerning what is "normal" and "usual" for the infant's development and growth. Then abnormality will be more easily detected.

The Health Units and their Well Baby Clinics might be an excellent medium for that type of work, provided that there is available on the spot trained personnel in recording data. This view is already expressed by the United States Academy Study of Child Health Services stating: "No matter how strong the statistical team at the Central Office, the value of the results will be limited by the diligence and accuracy with which this data is collected and reported by the state executive secretaries. (The Journal of Pediatrics, 1946, 29, 523).

Further study covering the whole province, if possible, would secure more exhaustive information and elucidation of the mentioned problems of babies' growth and development, and without doubt would advance the progress of breast feeding.

Summary

This inquiry is concerned with the problems of feeding and development of babies in the Swan Valley Unit Area. Amongst many factors influencing this favourable progress, prenatal care and feeding were most important and have been discussed in this paper dealing with 135 pregnant women and 1,225 babies. It is calculated that an average baby's birth weight in the area is 7.265 pounds for girls and 8.015 pounds for boys.

The decline in the incidence of breast feeding and shortening of its duration period is evident in the series of 624 baby boys and 601 baby girls, as only 30.1% and 30.8% respectively of boys and girls were breast fed at the end of their first month of life. Although the artificially fed babies were doing well, the plea for breast feeding as the natural, most satisfactory and safest way of feeding is stressed.

Acknowledgment

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Anaesthesiology

Abstracts

Anaesthesia and the Cardiac Patient, Graham W. Hayward, Anaesthesia, 7: April, 1952, 67.

"Most patients with heart disease tolerate surgery well and the operative mortality is very little higher than that in patients with a normal heart. If the operation is carried out by a competent surgeon and anaesthetist the strain on the heart is less than that imposed by even moderate exertion and if the cardiac patient has been free from symptoms suggesting myocardial insufficiency few difficulties should be anticipated. There are two factors which may seriously embarrass the cardiac patient during the surgery. The first, anoxia, is usually under the care of the anaesthetist and should rarely occur in significant degree. The second, Hypotension.

Anoxia is dangerous, even in slight degree, in a patient with cardiac disease and should be especially guarded against in the patient presenting symptoms suggesting myocardial insufficiency. In coronary heart disease sudden death from ventricular fibrillation may be caused by anoxia; this group of patients includes those with a history of angina pectoris, recent coronary occlusion, aortic valvular disease, syphilitic aortitis, heart block of all degrees, and some patients with a large patent ductus arteriosis.

To minimize the risk of ventricular fibrillation it is wise to administer pronestyl (procaine amide hydrochloride) pre-operatively. If arrhythmias occur during operation, pronestyl may be given intravenously, 100 mgms. per minute up to 1000 mgms.

The amount of blood flow through the coronaries is determined by the blood pressure. "From a cardiac point of view, prolonged induced hypotension may be dangerous in middle-aged or elderly patients because of the impossibility of detecting pre-operatively some cases of severe coronary disease where cardiac infarction may be caused."

Elective surgery should not be performed in the presence of congestive heart failure. Emergency surgery may, however, be essential. Time must be allowed for rapid digitalization. e.g. 1 mg. digoxin intravenously or 1.5 mgms. by mouth. Mercurial diuretics should be started at once. Auricular fibrillation does not add to the difficulties, providing that the ventricular rate is controlled with digitalis. Infrequent ectopic beats are not significant. Abnormalities of conduction, as revealed by the electrocardiogram, are commonly the result of coronary heart disease and add little to the risk providing anoxia and hypotension are carefully guarded against.

M. Minuck, M.D.

Blood Loss During Operations, H. C. Saltzstein, M.D., and L. M. Linkner, M.D. J.A.M.A., 149, June 21st, 1951, 722.

Measurement of the blood lost in a consecutive series of 212 surgical operations revealed the following data:

1. Certain operations such as appendectomy, hernia, thyroidectomy, and cholecystectomy are accompanied by minimal blood loss, 20 to 200 ccs.

2. A middle group, including hysterectomy, colon resection, stomach resection is accompanied by losses ranging from 300-3,000 ccs.

3. Losses greater than 1,000 ccs. are likely to take place during radical breast operations, abdomino-perineal resections, combined neck and jaw resections and extensive intra-abdominal dissections for large adherent tumors.

4. Average of blood loss values obtained for a given operation vary with different surgeons.

5. Correcting pre-operative anemia and replacing blood lost during the operative procedure contributes in a surprising degree to freedom from post-operative complications.

The Gravimetric method for measuring blood loss was used, i.e. simply weighing the soaked sponges and comparing this weight to the weight of a similar number of dry sponges. If moist sponges have been used the amount of saline or water used can easily be measured and added to the weight of the dry sponges. An ordinary diabetic scale of the dial and pointer type accurate to 0.1 grams can be used.

M. Minuck, M.D.

Article

The Orthopaedic Congress of the English-speaking World London, June 28 to July 12, 1952

Alexander Gibson, F.R.C.S.

This is an era of Conventions, Conferences and Congresses. Each and every group that is conscious of ties of business, professional interest, political aspirations, or religious affiliations organizes a gathering at which common aims may be formulated, common problems discussed, and common social proclivities indulged. In this respect, orthopaedic surgeons are no different from their neighbours. There are countless orthopaedic groups, societies and associations, city-wide, province- or state-wide, or national in scope. Sometimes international assemblies are convoked. These, in my experience, are not a success. It is difficult to get on terms of full understanding with a man whose language you do not speak, and to whom your language is quite unknown; those who attend such linguistic jamborees generally return home with their appreciation of the "foreigner" not perceptibly modified. Where all the members of the Conference speak the same language, even with territorial idiosyncrasies, the barriers are down; all can meet on common ground. Their observations, their discoveries, their triumphs, their failures can be expounded to their colleagues as readily as to their own associates in their own hospital surroundings.

This was the conception underlying the recent London meeting. The basic fact was that all spoke English. It was thus possible to assemble in one comprehensive group members and fellows of the British Orthopaedic Association, of the American Orthopaedic Association, of the Canadian Orthopaedic Association as well as representatives from the Orthopaedic Associations of South Africa, Australia, and New Zealand. The British acted as hosts; the reception tendered to their guests was truly magnificent. Their courtesy was impeccable, their thoughtfulness meticulous, their generosity unstinted. As a group and as individuals, their kindness and hospitality were measureless. Not only in London, but throughout England and Scotland, hospital demonstrations were organized and receptions arranged. Everywhere our hosts threw wide open to their visitors the doors of their own homes. From its impressive commencement until the final words of appreciative thanks were spoken, there was not an hour of the Congress uncharged with interest, not a moment undeserving of remembrance.

On the afternoon preceding the opening of the meeting, Sir Reginald Watson-Jones, the British President held a reception at Claridge's. This gesture proved an outstanding success. For several hours the guests intermingled, refurbishing old friendships and forming new ones. In consequence of this, when the business of the Congress got under way next day, the cloak of national reserve had worn somewhat thin, and an atmosphere of "camaraderie" was definitely established.

The Inaugural Ceremony

Full advantage was taken of the opportunity to stage a colorful and impressive ceremony. The scene was the Senate Hall of the University of London. From 10 a.m. until 11 a.m. the members and guests seated themselves in the Hall while the band of the Grenadier Guards played selections from Elgar, Schubert, Mozart, Beethoven, Handel and others. Meanwhile Queen Elizabeth, the Queen Mother, was received in the South Hall of the University by the Chancellor, the Earl of Athlone, a former Governor-General of Canada, and other dignitaries. Thereafter, the Lord President of the Council, the High Commissioners of the Commonwealth, a representative of the American Ambassador, the Presidents of the Royal Colleges of Great Britain and Ireland, the Presidents of the Orthopaedic Associations and other distinguished guests were presented to Her Majesty. A procession was then formed to enter the Senate Hall. All taking part were in academic dress. Representatives from the U.S.A. and the British Commonwealth, from Italy, Portugal, the Argentine, Brazil, from Denmark, Sweden, Norway, Finland, France and the Netherlands were marshalled in colorful file, and proceeded to the seats reserved for them. Next came the Royal Procession, culminating in the much-loved personality of the Queen Mother. The proceedings were opened by the singing of the National Anthem followed by a speech of welcome by the Chancellor of the University, the Earl of Athlone. The main speech of the morning was delivered by Sir Reginald Watson-Jones, the president of the British Orthopaedic Association. In reply to this, the Queen-Mother spoke in appreciative terms of the work being done throughout the world by orthopaedic surgeons.

After this there came what was to overseas visitors at least, the most interesting part of the ceremony. For the presidents of the American and Commonwealth Associations the fellows and members of the British Orthopaedic Association had had designed and prepared jewels of office. All of these jewels had a central theme, signifying the art of Orthopaedic Surgery, but each jewel

differed from its fellows; e.g., the American one displayed an eagle in the clasp, while the Canadian one showed a maple leaf interwoven with the fleur-de-lis. The jewels were draped around the neck of each president by the gracious hands of the Queen-Mother. In doing so she manifested the incomparable charm which has so endeared her to her peoples. A few smiling words to the recipient accompanied each presentation, followed by a little adjustment of the decoration ending with a little pat to make sure that it hung straight. It was unerring instinct to infuse a touch of ease and informality into a very formal if not indeed a rather formidable occasion. In a few happily inspired words the various presidents acknowledged the gift; the jewels were worn by their respective custodians throughout the meeting. A short speech by Lord Woolton, the Lord President of the Council brought the ceremony to a conclusion.

The Scientific Programme

Some thirty-four papers were presented. Of these fifteen came from Great Britain, thirteen from the United States, two from Australia, and four from Canada. The Canadians were selected from Montreal, Toronto, Winnipeg and Vancouver. The standard of the presentations from every region was of high quality; it was noteworthy that the disabilities of the hip-joint came in for a good deal of attention.

Special lectures were given at the Royal College of Surgeons by Sir Max Page on "The Effects of War on Surgical Practice," and by Dr. Leo Mayer of New York on "The Development of Tendon Surgery." These lectures afforded an opportunity to the visitors to view some of the treasures of the Hunterian and College Museums such as Amputation sets used at the battle of Waterloo. One afternoon was spent in a visit to the Royal National Orthopaedic Hospital at Stanmore. The hospital itself consists mainly of old army huts, but these unimpressive structures have imposed no obstacle to the production of first-class work, including much of a research character. Of timely interest was a demonstration of spinal cord changes in Poliomyelitis. Another demonstration on the replacement of bone by plastic prostheses was definitely in advance of current surgical practice. The enthusiasm of the workers was conspicuous. On the afternoon of July 4th a series of demonstrations had been arranged at the leading London hospitals, St. Bartholomews, the Royal Free, Guy's, King's College, The London, The Middlesex, and St. Thomas'. I chose St. Thomas' and was much gratified by the conservative attitude that pervaded the treatment of fractures and other orthopaedic disabilities. One would have enjoyed an opportunity to see the work of some of the other hospitals, but only a jet-propelled shuttle system could have made this possible. Probably on the occasion of the next English speaking Congress in London, a gigantic television screen combined with radio intercommunication will enable us to sit comfortably in upholstered chairs while the demonstrators show their cases and answer our questions. Quien sabe!

Social Activities

These were numerous and varied. They included receptions at the homes of British members and fellows, dinners at various hotels of groups with a common interest, visits to the Houses of Parliament, a Golf Competition at Sunningdale (won, incidentally, by a Canadian from Vancouver), and a visit to the Royal Henley Regatta. Canada Day was not forgotten. On July 1st, the string orchestra of the band of the Grenadier Guards played from 9 a.m. until 9.30 a.m. after which the audience stood for the Canadian National Anthem. On July 4th a similar compliment was paid to the United States of America, the concluding item on the programme being the American National Anthem.

Probably the outstanding social events were three in number. The first of these was held on June 30th. A special Ballet performance of "The Sleeping Princess" was given at the Royal Opera House, Covent Garden. The costumes and the décor were magnificent, set off to advantage by the spacious stage; the dancing was superb and the whole spectacle one of breath-taking beauty. A second event was the official Dinner of the Congress held at the Dorchester Hotel. The organization of this very large gathering commanded admiration as did the service provided. Toasts to "The Guests" and to "Orthopaedic Surgery" were proposed and honoured, and then the main toast of the evening "The English Language" was proposed by Lord Reading, and responded to by Lord Justice Birkett. These were memorable speeches. Every guest was impressed by the choice diction and the eloquent oratory of the speakers.

In the early part of the evening of July 4th, Dr. Fremont Chandler, the President of the American Orthopaedic Association held a reception at Claridge's. The atmosphere was amicable in the extreme. The third outstanding social event was designed as a sort of Fourth of July celebration at Hurlingham Club. It was a fitting wind-up to an eminently successful week. There was a fire-work display, dancing and a cabaret show at which the entertainers were Miss Mary Martin of "South Pacific" renown and Mr. Noel Coward. Refreshments rounded out a notable evening.

The following morning visits were arranged to various places of interest. Some of us chose to go to Canterbury; there we spent a most enjoyable day in the historic Cathedral and the city.

During the ensuing week those who wished might take one of two tours; to the south-west including Exeter, Bath, Stratford-on-Avon, Birmingham, Oxford, Windsor, or to the north-west visiting Shrewsbury, Oswestry, Chester, Liverpool, the Lake District, and Edinburgh.

Thus ended a very memorable occasion. It is certain that such a gathering has never before been arranged, and it is unlikely that an assembly of such dignity and of such significance will again be held during the lifetime of most of us.

As the days pass, it becomes increasingly evident to thinking men that closer integration of the English-speaking world is the most promising approach to the problem of quieting international turmoil. In specific terms that means a deeper mutual understanding on the part of the British Commonwealth of Nations and the United States of America. A gathering such as that of the Orthopaedic Congress cannot have failed to play its part in proving that behind national idiosyncrasies our modes of thought, our principles of conduct and our ideals are one. Those of us who had the privilege of attending the meeting can only say with Philario,

"Your very goodness and your company
O'erpays all I can do."

Medico-Legal

Civil Liability of Physicians and Surgeons

A paper delivered to the Manitoba-Medico Legal Society at Winnipeg, March 25th, 1952, by B. V. Richardson, Q.C., of Richardson, Richardson, McLachlan & Carpenter, Barristers and Attorneys-at-Law.

General Principles

A man who practices a profession is bound to exercise the skill and competence of an ordinary competent practitioner in that profession. It follows that an action for negligence will lie for damages caused by the failure to exercise due care and skill by proving either that the defendant did not possess the requisite skill or by showing that, although he possessed it, he did not exercise it in the particular case. The above rule applies equally to the two professions represented in this Society. We will not here trouble ourselves as to whether the action is based on contract or in tort. However, it would appear that the right-of-action, if any, against the doctor lies in tort and that the lawyers' liability arises from contract.[1]

The civil liability of medical men towards their patients has been stated as follows:

"If a person hold himself out as possessing special skill and knowledge and he is consulted, as possessing such skill and knowledge, by or on behalf of a patient, he owes a duty to the patient to use due caution in undertaking the treatment. If he accepts the responsibility and undertakes the treatment and the patient submits to his direction and treatment accordingly, he owes a duty to the patient to use diligence, care, knowledge, skill and caution in administering treatment . . . The law requires a fair and reasonable standard of care and competence."[2]

Neither the highest nor a very low degree of care and competence judged in the light of the particular circumstance of each case, is what the law requires. A person is not liable in negligence because someone else of greater skill and knowledge would have prescribed different treatments or operated in a different way.[3]

Diagnosis

Failure to use skill in diagnosis, so that the wrong treatment is given is negligence. A competent practitioner will know when a case is beyond his skill and thereupon it becomes his duty either to call in a more skilful person or to order the removal of the patient where skilled treatment is available[4], although in at least one Canadian case where it was found that the physician in charge of a case was unable to diagnose the trouble promptly he was not under legal obligation so to inform the patient and to advise the calling in of a specialist[5]. In such case a qualified medical practitioner who was in charge of a hospital maintained by the defendant company failed to diagnose ear trouble from which the plaintiff was suffering as being mastoiditis which it eventually turned out to be, and although the physician was unable to ascertain what the exact trouble was he did not send for nor advise sending for a specialist. Medical evidence at trial showed that in its early stages it is difficult to diagnose mastoiditis with reasonable certainty and it was held that it could not be said that in his diagnosis the physician did not bring to bear such reasonable care as might be expected. In another case the plaintiff had fallen on the street and injured her shoulder and called in the defendant doctor who made a thorough examination at which he applied the usual and proper test for discovery of dislocation and came to the conclusion that there was no dislocation. He advised massage and requested the patient to see him again in a few days' time. This however, she did not do and after a lapse of four months, her shoulder failing to improve, she consulted another doctor who took an x-ray which showed that the shoulder was dislocated. The

lateness of the discovery necessitated an operation. The surgeon who performed the operation stated in evidence that the shoulder did not react to the usual test for dislocation, due, in his opinion, to a congenital malformation. The physician was sued and at trial found liable which decision was however on appeal reversed, it being held that it was not under the circumstances negligence not to take x-rays.[6]

Duty to Attend and Treat

Negligence may consist in failing to obey an urgent summons from a person who has been accepted as a patient[7]. However, in one case the defendant, a physician and surgeon, agreed to attend the plaintiff at childbirth and was notified by the plaintiff's husband that labour had commenced and was requested to attend immediately. The defendant after due enquiry as to the frequency of the labour pain stated that he could not conveniently attend before a certain time. The husband agreed to this, remarking that the nurse who was in attendance had given it as her opinion that the child would not be born until much later than the time the defendant had given for his arrival. However, the birth commenced and was completed before that time and the child having died the plaintiff brought an action for damages alleging negligence or breach of duty and at trial the plaintiff succeeded and damages were awarded against the doctor. On appeal the case against the doctor was dismissed. He knew that an experienced mid-wife was in attendance, and the medical testimony was to the effect that the frequency of the labour pains was an indication that his attendance would not be necessary until a later hour than that named and it was held that his failure to attend before that time could not be regarded as negligence. The court said that the plaintiff's contention that when a doctor undertakes to attend a case of this nature he thereby undertakes to drop all matters and to attend the patient instantly upon receiving a notification, was wrong. A doctor, having regard to the circumstances, must act reasonably; he has other patients who have claim upon his time and attention.[8] Further it has been held that a physician has a right to leave his practice temporarily if he makes provision for the attendance of a competent physician upon his patients. If he notifies a patient that he is going away, and indicates who will attend him in his stead, no neglect can be imputed to him[9].

Circumstances a Factor in Determining Degree of Care and Skill Expected

There is much to be said as to the degree of care and skill expected from a country practitioner, attending an injured person as contrasted with a surgeon, operating with all the comforts and equipment of a hospital. To quote from the law reports "it surely cannot be that the skill of a physician, attending a patient in a private house with few conveniences, and no assistants, is to be measured by the same standard as a city surgeon, provided with an operating room, assistants, nurses, and all the aids of a modern hospital."[10]

An exceptional high degree of care and skill has been required by the courts in the use of comparatively new forms of treatment. In one case, the defendant, a registered medical practitioner, was found guilty of the unsuccessful and negligent use of certain electrical treatments known as the "Quartz light," a decision which was affirmed on appeal, one of the judges saying that:

"What impresses me as a serious point in the matter is that great care was not exercised either at the time it was used or afterwards. It is clear that the properties of the ultra-violet ray as well as the x-ray and radium are not perfectly understood . . .

The court then continued by quoting from Taylor's Medical Jurisprudence as follows:

"Much expert and scientific knowledge will be demanded of him who uses the rays and thereby causes damage, should he be called upon to compensate for such injuries. When a person uses a comparatively new power or force, the properties of which are not fully known or understood, such as this quartz light, it is incumbent upon him to exercise very great, if not the greatest care possible in its use."[11]

The probabilities are that this line of reasoning would be followed by the courts in considering the liability of the physician or surgeon where any new treatment known to be associated with possible dangers of its use is in fact used. In another Canadian case, it is said that a higher degree of skill than that of the general practitioner is required of one who holds himself out as a specialist.[12] On the other hand, in another case, the patient brought an action against the physician for damages for burns sustained because of alleged negligence in the operation of an x-ray machine. It appeared that the injuries were sustained when the plaintiff, after being warned by the operator of the machine to lie perfectly still, came in contact with the lamp through an involuntary movement. It was held, reversing the judgment at trial, that there was no negligence or want of care on the part of the physician. The evidence showed that everything connected with the treatment, the apparatus and its operation, was in accordance with good practice adopted by others in the same line of work. The plaintiff being a person of average intelligence, the warning or instruction given by the operator was reasonably sufficient under the circumstances.[13]

The Extent of Duty

If the physician or surgeon supply the equipment then he is responsible for seeing that the equipment is reasonably efficient under the cir-

cumstances. Unless operating in a hospital where such services are supplied by the hospital he is responsible for proper sterilization. He is particularly responsible for the care of a person being operated on with a special duty towards the unconscious person.[14] A surgeon has been held responsible for not exercising due care in the selecting of the anaesthesist.[15] The practice of his profession as a physician includes the management of the patient and of the disease, as well as of the means or method of curing, and is not confined to the administering or prescribing of drugs, or any specific treatment.[16]

Refusal to Take Case

It has been held by the courts of the United States that a physician is not bound to render professional services to everyone who applied and may refuse to respond to the call of a patient although he is the only physician available.[17] The same conclusion would likely be arrived at in Canada.

Gratuitous Service

If a physician or surgeon treats a patient improperly he will be held liable for damages suffered even though he has undertaken to attend the patient gratuitously.[18]

Practicing in Partnership

Where physicians or surgeons engage in practice as partners all are liable for mal-practice by any member of the firm.[19]

Liability for Servants or Assistants

The rule that the master is liable for the negligence of his servant or servants applies to the medical profession. The surgeon can be liable for the negligence of say a student assistant [20] or a technician. While receiving x-ray treatments from the defendant physician, the plaintiff was injured by reason of the negligent manipulation of the apparatus by the physician's servant. It was held that the physician was liable as a master for the negligence of his servant.[21] On the other hand, in the absence of knowledge to the contrary or of facts sufficient to put him on inquiry, a surgeon visiting a hospital to treat a patient has the right to assume that its nurses, not hired by him are competent.[22] A Chief Justice of one of the provinces with whom the other members of the Court agreed, has said:

"I do not think it can be said wholly as a matter of law that at every operation the chief surgeon is responsible for whatever may occur there, or even that in every case he is liable for negligence on the part of an assistant. Something may depend upon the character of the operation, and there may be established rules and customs among surgeons that must be taken into account. The Court has no knowledge of operating-room procedure or practices, nor can it say, without evidence, when an assistant is reasonably required or for what purposes he may be used. So long as the presence and participation of an assistant are proper, and the assistant is a duly qualified surgeon with the skill and experience necessary for the work properly entrusted to him, I do not see how, purely as a matter of law and without evidence, the Court can find the chief surgeon responsible for negligence of the assistant."

The Plaintiff had been severely burned while being prepared in the operating room for an operation performed by the Defendant. Alcohol had been used in preparation, and it was suggested, but not established by evidence, that the alcohol had been responsible for the burns. Since there was no evidence as to how the burn was caused, and no evidence that the Defendant surgeon had been in any way negligent, or had failed to observe the proper practice, the action was dismissed, a Judgment which was affirmed on appeal to the Supreme Court of Canada.[23]

Consent to Operate

A surgeon requires consent to operate. Otherwise, he probably becomes liable for damages in an action based on the tort of trespass to the person. If the person to be operated on is an adult and of sound mind then his consent should be obtained. The consent of one's spouse is not necessary for an operation on the other.[24] If the patient is an infant, that is under the age of twenty-one, then the consent of the parent or guardian should be obtained, otherwise again the surgeon can be held liable for damages in trespass to the person. If the person to be operated on is unconscious and immediate operation is necessary the court could imply consent or could hold that the surgeon had the defence of necessity.[25] If the patient is known to be incapable of giving consent because of say intoxication, or mental incompetence, it has been said that the mere desirability of treatment in such cases will not justify the surgeon in going ahead without the consent of the patient or at least the consent of a parent or husband or some other person who represents the patient, but if an emergency arises which threatens death or serious bodily harm, as where the patient is bleeding to death, it is generally recognized that the surgeon must be free to operate without delaying to obtain consent. It is said that in these cases the consent is "implied" under the circumstances. It is perhaps more correct to say that the surgeon is privileged because he is reasonably entitled to assume consent and to act as if he had been given it.[26] A surgeon who exceeds the authority given to him by the consent may also make himself liable for trespass to the person. He has no authority to take an additional step at the time of the operation without the consent of the patient notwithstanding the possibility of some future hazard nor the convenience or desirability as in his opinion may be

to prevent such further danger. That risk is one that should be left to the decision of the patient; although it has been said that if it is necessary to do additional surgery in the sense that it would be, in the circumstances, unreasonable to postpone the operation until a later date the surgeon would have that authority.[27]

Burden of Proof

There is a presumption that the physician and surgeon knows his work and does it properly. He has no need to produce evidence of his general skill and fitness. He is considered prima facie competent and on the claimant lies the onus of proof to the contrary.[28] The defendant, a surgeon, in performing an operation on the plaintiff relied upon the word of a nurse whose duty it was to count the sponges used to see that all the sponges were accounted for. One of the sponges however was left in the wound, preventing it from healing, and causing additional pain and suffering to the plaintiff. In an action by the plaintiff for damages it was held that the surgeon was not guilty of negligence. On the evidence, the nurse was supplied by the hospital where the operation was performed, and the duty of keeping count of the sponges was properly delegated to her.[29] In another case, the negligence alleged was the leaving of a rubber drainage tube in an incision made by the defendant, a surgeon. The defendant claimed that he ordered the tube removed, and took the assurance of the nurse that this had been done. The Trial Judge found the defendant negligent on the ground that a competent and alert practitioner would have discovered the presence of the tube and have had it removed long before the time which elapsed before its discovery. On appeal the Court of Appeal without written reasons reversed this judgment, holding that no negligence on the part of the defendant had been shown. The tube being left in the wound was the fault of the nurse. It was held further that in the absence of evidence that it was the duty of the defendant to advise that an x-ray be taken, it was not to be inferred that the defendant was negligent in not so advising. On the other hand, where a sponge was left at the base of the patient's nostrils causing suffocation, and the surgeon knew that there were available upon request sponges with tapes attached and also the services of a nurse for the counting of sponges used, and did not take advantage by either method of the opportunity of checking his sponges, he was found liable, the court saying that the fact that the surgeon followed his usual practice and that it was one followed also by other surgeons, did not necessarily constitute a complete defence; if a practitioner does not take the obvious precaution he cannot exonerate himself by showing that others also neglect to take such precaution.[30]

Negligence of a physician or surgeon must be definitely established against him by the claimants. In an action against a surgeon for malpractice one of the medical witnesses called for the plaintiff stated, although not in terms condemning the defendant's treatment or alleging negligence, that he would have pursued a different course. Evidence for the defendant, however, showed clearly that the course of treatment pursued by him was such as would have been adopted by medical men of competent skill and good standing. It was held that there was no evidence of negligence to submit to the jury and the case was dismissed.[31]

In another case the plaintiff sued the defendant, a surgeon, for malpractice in performing an operation on the plaintiff's wife, which the plaintiff alleged should not have been performed. It was held, affirming the judgment at trial dismissing the action, that the evidence only established that the method of operation pursued by the defendant was an established practice but one of which some surgeons did not approve, and did not constitute malpractice. The court said as follows:

"It is notorious that operations by the best surgeons may be unsuccessful and followed by untoward sequelae, that the surgeon does not guarantee success or perfect results but only that he has and will use a reasonable degree of skill and learning and that he will exercise reasonable care and exert his best judgment to bring about a good result. Even if an untoward result were proved . . . it would be contrary to all our Jurisprudence to convict a practitioner of ignorance or neglect without evidence that such result was due to his fault."

[32]The burden of proof is also upon the patient who alleges that an operation was performed without his consent.[33] Where there is conflict of evidence as to consent it is purely a matter of credibility and the plaintiff has to satisfy the onus of proof upon him as to his allegation that the operation was unauthorized.[34]

Duty to Inform Patient

In treating a patient by injections into the muscle known as the gluteus maximus the needle broke off and the defendant surgeon was unable to get it out of the patient's body where it remained some five or six days when it was removed by operation in a hospital. The operation left a scar and according to the patient she suffered pain and sleeplessness and had been unable to do her household work. The injections had brought good results, and the court found that there was nothing to show that the defendant was guilty of any lack of skill and care in the way in which he gave the injections in question, but the court said that this was not the whole of the case. The surgeon knew at once that the needle had broken

off and that the point of it remained in the patient's body. The patient said that she did not know that it was in her body and the doctor said that he had not told her because her husband had impressed on him that owing to her illness and her nervous condition she was not to be told anything that would upset her. The question was whether the doctor had failed to do what it was his duty to do. The court said that the patient in whose body a doctor found that he had left some foreign substance was entitled to be told at once, and that it was most important that the doctor should tell the patient or her husband before she left the surgery where the treatment had been given.[35]

Damages

It is generally considered that this is a subject separate and apart from the question of liability. It is hoped therefore that it is suffice to say that damages, where liability is found, would include the following:

(a) Special damages for additional expenses incurred by the patient for other medical advice and treatment, additional hospitalization expenses, drugs, etc.
(b) Loss of earnings.
(c) General damages for shock, pain, suffering and disability.

Limitation of Right of Action or Claim

There is a period of limitation within which any civil right or claim must be commenced in the courts. "The Medical Act" being the Statute of Manitoba pertaining to the practice of medicine and surgery within the province provides by Section 74 thereof that:

"No duly registered member of The College of Physicians and Surgeons of Manitoba shall be liable in any action for negligence or mal-practice by reason of professional services requested or rendered, unless the action is commenced within one year from the date when, in the matter complained of, such professional services terminated."

A similar provision in Ontario has been interpreted by the courts as taking away the patient's right-of-action after the lapse of one year although the patient was an infant[36]. Presumably the same decision would be reached in Manitoba and this irrespective of what constituted the disability of the patient that is whether it be infancy, insanity or confinement in penitentiary or goal.

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9. 48 Corpus Juris, Page 1130.
10. Zirkler vs. Robertson (1897), 30 N.S.R. 61.
11. Baills vs. Boulanger (1924), 4 D.L.R. 1083 (Alta. C.A.).
12. McCaffrey vs. Hague (1949), 2 W.W.R. 539 (1949), 4 D.L.R. 291.
13. Andoniuk vs. Smith, 1930, 2 W.W.R. 712, 4 D.L.R. 215.
14. Corpus Juris, Page 1119.
15. Corpus Juris, Page 1121.
16. Baltzan vs. Fidelity Insurance Co. (1932), 3 W.W.R. 140, affirmed without written reasons (1933), 3 W.W.R. 203.
17. Corpus Juris, Page 1124.
18. Town vs. Archer (1902), 4 O.L.R. 383.
19. Town vs. Archer, Supra.
20. McNamara vs. Smith (1934), O.R. 249.
21. Hochman vs. Willinsky (1933), O.W.N. 79.
22. Bugden vs. Harbour View Hospital (1947), 2 D.L.R. 338 (N.S.).
23. McFadyen vs. Harvie (1942), S.C.R. 390; (1942) 4 D.L.R. 647 affirming (1941) O.R. 90 (1941) 2 D.L.R. 663.
24. Mulloy vs. Hop Sang (1935), 1 W.W.R. 714.
25. Winfield on Tort, Third Edition, Page 26.
26. Prosser on Tort, Page 119.
27. Murray vs. McMurchy (1949), 1 W.W.R. 989 (1949) 2 D.L.R. 442 (B.C.).
28. Jewison vs. Hassard (1916), 4 W.R.L. 904.
29. Thomson (Thompson) vs. Barry, 41 O.W.N. 138, reversing without written reasons, 41 O.W.N. 14.
30. Anderson vs. Chasney (1949), 2 W.W.R. 337 (1949) 4 D.L.R. 71.
31. Fields vs. Rutherford (1878), 29 U.C.C.P. 113 (C.A.).
32. Davy vs. Morrison (1932), O.R. (1931) 4 D.L.R. 619.
33. Turner vs. Toronto General Hospital Trustees (1934), O.W.N. 629.
34. Turner vs. Toronto General (supra).
35. Gerber vs. Pines, K.B.D. (1934), mentioned Thomson Law of Negligence, Canada, Page 550.
36. Miller vs. Ryerson (1892), 22 D.L.R. 369 (C.A.).

Historical

45 Years Ago — Continued

From the Western Canada Medical Journal

Vol. 1, No. 6 of the Western Canada Medical Journal, for June, 1907, opens with an original article entitled "The early broncho-pneumonia of typhoid fever," by Percy Kidd, M.D., F.R.C.P., Physician and Lecturer in Medicine to the London Hospital. It appears that enteric fever was quite common in London as well as in Winnipeg too in those days. In contrast, and in conjunction, the next article is "Typhoid Fever—its treatment in rural districts," by Murrough C. O'Brien, M.D., C.M., Medical Superintendent, Roseau Hospital, Dominion City, Man. Dr. O'Brien believes the essential feature of treatment is **nursing.** With this he combines diet and drugs, and states "ever since I adopted my present method, I have had no relapses, no complications and no deaths."

"The Preservation and Promotion of Human Health," by C. J. Fagan, B.A., M.D., Ch.B., Provincial Medical Health Officer, Victoria, B.C., was read before the Vancouver Teachers' Association. The importance of good hygiene in maintaining good health was at that time a new idea and Dr. Fagan, whose appointment corresponded somewhat to that of a present Deputy Minister, lost no opportunity to educate the public.

A letter to the Editor, entitled "Sunlight is Injurious to the Tuberculous," brings the first support so far recorded in favor of the proposition previously submitted by the Rev. Dr. Huestis. It is from the pen of Chas. E. Woodruff, M.D.

As a Special Article, the meeting of the American Orthopedic Association at Washington, D.C., is reviewed by Herbert Galloway, M.D., Vice-President of the American Orthopedic Association and Professor of Orthopedics, Manitoba Medical College. The topics discussed then would still be of interest today.

"At the recent meeting of the Local Council of Women, held in the Y.M.C.A., Winnipeg, the president made a very good suggestion, namely, the establishing of a Children's Hospital."

"The Winnipeg Army Medical Corps is fast gaining in strength. All men desirous of going to Sturgeon Creek Camp must register not later than June 12th."

"Dr. and Mrs. Reid had a bad accident at the new C.P.R. crossing, Didsbury, May 30th. Mrs. Reid is suffering from a sprained ankle."

"Dr. W. E. R. Coad is leaving Franklin, 1st June, to go for a tour to the old country and Europe before resuming practice."

"Dr. McLeod, Stonewall, has gone for a trip to Japan."

This issue contains the first, of many, reports of the College of Physicians and Surgeons, Manitoba. (We wonder if they were charged the same high rates as now). The actual cash received during the year (?1906) was as follows, viz.:

From licences, etc. by Dr. Gray	$5,039.75
Nurses' fees (? for what)	377.40
Interest on money in bank	30.11
	$5,447.36 (sic)

A full page ad exhorts you to "PUT YOUR MONEY Where it Will do the BEST WORK for YOU. . . . become a stockholder in the finest store on Fifth Avenue (N.Y.). Those who buy now realize much greater profits than those who wait."

No. 7 for July opens with an original communication "The Role of the General Practitioner in the Advancement of Medical Science," by James Mackenzie, M.D., F.R.C.P., Burnley, England. To cite extracts from this article would be to murder it. It could be read today, with profit, before any medical group.

A paper on "Displacement of the Uterus" by C. N. Cobbett, M.D., Edin. of Edmonton, was read before the Northern Alberta Medical Association. It is a long and logical dissertation accompanied by interesting discussion by various members. Dr. Cobbett makes a plea for operative repair (apparently a new idea) in cases where pessaries and drugs fail to effect a cure.

From the editorial section we learn "One point in support of raising the fees is that of late years the cost of living in the West has gone up by leaps and bounds, and the cost of labor in proportion. Even teachers' salaries, which are said to be always the last to move, have increased—but the medical fees have remained **stationary."** Where have we heard that before? . . . and since!

A "Letter to our Subscribers" confirms the healthy state of the newly found journal. "That the West is asleep or incapable of intellectual effort, as was said when the idea of this journal was mooted, has been utterly disproved . . . the Journal must be **independent** . . . has no bias . . . no purpose than to be . . . the **voice** of the Medical West."

"The members of the Saskatchewan Medical Association met in convention at Prince Albert on Thursday, June 20th, but so tempting was the entertainment provided by the local medicos . . . that business was not fairly commenced until Friday morning."—A nice private inside peek into the social habits of our predecessors!

There were 71 deaths in Vancouver in June, 1907, including children's complaints 5, natural causes 2, liver complaint 1, infantile weakness 2, congenital weakness 1.

"A $12,000 hospital is to be built this year at Souris, Man."

"Dr. Culbertson, Dauphin, had the misfortune to have his summer cottage on the Wilson River burnt."

"Dr. R. M. Simpson, Winnipeg, has gone to Europe for a holiday."

Married. "Waugh-Potts—At Carberry, June 21st, Dr. R. J. Waugh to Miss Kathleen Potts, of Carberry."

No. 8, August, 1907, leads with an original article on "Infant Mortality," by W. G. Brock, M.D., D.P.H., Medical Health Officer, Germiston, South Africa. In South Africa and England the rate averaged 138 per 1,000. The next paper is on "The Medical and Surgical Treatment of Acute and Chronic Appendicitis," by W. Dow, M.D., of Regina, Sask. Geo. R. Peterson, M.D., of Saskatoon, reports a case of "Syphilis Insontium" (of the innocent). His patient, an English settler of good family, acquired the disease "while being shaved at a barber shop of bad repute in Saskatoon." "The Treatment of Epilepsy" is a review of current Viennese opinion on the subject.

The eighth annual meeting of the British Columbia Medical Association was held in the Parliament Buildings, Victoria. About 40 members were present and they decided to make **The Western Canada Medical Journal** their official organ.

"At Crystal City, Manitoba, a man was convicted of practising as a veterinary surgeon without the necessary qualifications, and was fined $50 and costs, or one month. The Veterinary Association of Manitoba laid the information. Thus the animals are protected!" This refers to the lack of medical organization throughout the West, as the result of which many irregulars were allowed to practice unmolested.

The Grand Trunk Railway System advertise fares from Winnipeg to Toronto and return for $39.70.

Chandler & Fisher Ltd. advertise Bausch & Lomb Microscopes for "$75.00 Cash."

On the title page of No. 9 for September, 1907, we note the omission of the name of the Managing Editor, Dr. Harry Morell, and we find an editorial note to the effect that "Dr. Morell found he could not continue this part of his work, so his place had to be filled" . . . but no mention of by whom. As a matter of fact our suspicions were aroused in the July issue where a small ad appears, stating that Dr. Morell "begs to announce that he is prepared to make examinations of Sputum, Urine, Blood, etc., for the profession" . . . as though he were heating another iron. The same ad re-appears in the August issue but coincident with the Editor's announcement as above—the ad disappears—apparently forever. The name of Dr. Harry Morell cannot be found on the Register of the College of Physicians and Surgeons of Manitoba.

This number opens with the President's address delivered at the Eighth Annual Meeting of the British Columbia Medical Association by R. L. Fraser, M.D., of Victoria, B.C. "With an estimated population of 250,000, there are in the province 350 registered practitioners. We are all as yet general practitioners, the province not having so far produced many specialists."

His paper is followed immediately by "A Comparison of Post-operative Methods" by R. V. Dolbey, M.S., M.B. (Lon.), F.R.C.S. (Eng.) of Victoria, B.C. What price now all general practitioners in B.C.!

Dr. Dolbey states, "When we consider that the rectum can absorb 7-10 pints of fluid in the hour, in urgent cases, and (sic) absorb the fluid in a physiologically perfect condition we can see clearly why intravenous and intracellular methods of transfusion, not being physiological or therapeutically suited for the condition for which they are given, should be falling into disuse."

"Treatment of sequelae of Acute Osteomyelitis" by R. E. McKechnie, M.D., of Vancouver, B.C., asks "How often do we meet with a running sore on the leg due to a sequestrum in the tibia . . .?" (Has **anyone** seen one lately?) Dr. McKenzie believes the best method of preventing the formation of a sequestrum is to fill the cavity with a mixture of 60 parts iodoform and 40 parts each of spermaceti and oil of sesame.

Dr. James Duxbury of Elm Creek, Man., accepts the Editor's appeal of a few issues back and provides a report on "Difficulties in Practice Amongst the Indians." Typhoid and consumption were killing them off.

The Editorial in this issue concerns "The Conveyance of Typhoid" and is signed "R.S.T." We may presume this indicates Dr. R. S. Thornton of Deloraine, Man., later to become a Cabinet Minister. The Editor remarks "and here may we say a report has been circulated that many of these (recently published) papers were not **original**—referring to Osler, Jones, MacKenzie, etc. This is quite wrong—all our contributions are original unless definitely stated." "We need hardly repeat that we are come to stay—it is obvious."

The Canadian Medical Association had met at McGill University and had adopted a resolution "which will prevent any more homeopaths from being admitted to membership." The provincial vice-president elected for Manitoba was Dr. Harvey Smith, the provincial secretary, Dr. Gordon Bell.

A Special Meeting of the Winnipeg Medico-Chirurgical Society (the first mention of such an organization) "enjoyed a very exceptional treat . . . when Sir Lauder Brunton, of London, delivered an informal and impromptu address. There were certain drugs which were also of great value in keeping down arterial tension. Calomel and

Blue Pill were very useful agents to be given as required. These should always be followed by a saline a few hours later. Why the saline? The idea was to get the calomel to act upon the duodenum and, having obtained this action, to wash away the calomel before it got further down and became absorbed." (Simple, no?) The speaker was introduced by the President, Dr. E. W. Montgomery, a vote of thanks was proposed by Dr. Blanchard, seconded by Dr. Popham. The meeting is reported by Egerton Pope, M.D., Winnipeg.

In Winnipeg for August, 1907, there were 43 cases of typhoid reported with 2 deaths as against 100 other infections with 7 deaths. For August, 1906, the typhoid cases amounted to 192 with 12 deaths.

"We are glad to hear that Dr. Connell of Indian Head, who sustained a serious accident, fracturing two metacarpal bones and dislocating his left wrist while driving, is improving." This is but another of many accidents reported, the result of horse conveyances. It is our impression that the horse was more dangerous to the doctor than is the present day motor car.

Obituaries

On September 9th Dr. Claude Filbourne, of Winnipeg, died of typhoid fever.

On September 8th Dr. Earl Stewart also died of typhoid at the General Hospital, Winnipeg.

Vol. 1, No. 10, for October, 1907, carries as the leading article "A case of infective choleangitis with choleangiectosis" by Sidney Martin, M.D., F.R.S. (Eng.), Dean of the Faculty of Medicine, University College, London. Two cases are presented, one a fatal case of multiple hepatic abscess due to carcinoma of the bile duct, the other a case of infectious choleangitis in a man 21 who recovered following cholecystotomy.

A most interesting paper follows, entitled "Some Experiences in Pioneer Days," by the Hon. Dr. Helmcken, Victoria, B.C. The doctor, 82 years of age at this time, had gone to Victoria as surgeon to the Hudson's Bay Company when Victoria consisted of a Hudson Bay Fort only. We quote: "Dr. Helmcken went on to speak of his practice. He said he was a great man. He knew he was for he had seen the statement in a published pamphlet. It said he was at the head of his profession in Victoria. (Applause). The statement was perfectly true; for at that time there was not another surgeon within a hundred miles. The pamphlet went on to say he had been remarkably successful in his treatment. So he had been. There was no one to treat. All the citizens of Fort Victoria then were young men, all healthy. No one died."

There follows a short case history entitled "Roentgen Ray Treatment of Hodgkins's Disease," by Dr. Rundle Nelson of Victoria. A five-year-old boy was given seven exposures with gratifying results. (Please note the date—1906).

"The Surgical Treatment of Mesenteric Tuberculosis," by Dr. Ernest Hall of Vancouver, B.C., consisted in the marsupialization of a caseous mass of lymph nodes with complete recovery. This is Dr. Hall's second contribution to the Journal, the first having appeared in the April issue. He quotes "the pithy saying of (Lawson) Tait—that it is better to turn an exploratory incision into an operation, than to turn an operation into an exploratory incision."

A "Case of Infantile Mongolism," by E. Reavley, M.D., of Rosthern, Sask., is accompanied by an excellent photograph reproduced on a smooth-finished sheet.

"A Case of Appendicitis" from Edmonton is Dr. C. N. Cobbett's second contribution, the first having appeared in the July issue.

The editorial is a lengthy one of some 6 pages by Dr. J. R. Matheson of Prince Albert. It is entitled, "The Western University Question" and appears to rotate about a triad of proposals, namely, (1) no additional Western University (apart from Manitoba) is required, (2) the three remaining Western provinces should establish a common university and (3) each province should have its own. The die, however, had already been cast, definitely in the case of Saskatchewan, tentatively in the case of Alberta.

For some issues back the Editor has made it a habit to contribute a "Letter to our Subscribers." This month (we quote), "A report seems to be travelling around that the journal has changed hands. This is quite misleading. The change consists in the fact (as stated before) that Dr. Harry Morell, who had the management of the business side, has relinquished his interest in the Western Canadian (sic) Medical Journal, and his place in the management is now taken by Mr. Reginald Phillips. A glance at the editorial page will show that the control of that department remains as at the start with the addition of one or two names."

"The Annual Meeting of the College of Physicians and Surgeons of the Province of Alberta was held in Calgary on the fourth of September, 1907. . . . the question of Reciprocity between the three Western provinces—Alberta, Saskatchewan and British Columbia was discussed. . . . The question of including Manitoba was discussed, but the Council was of the opinion that . . . it could not be entertained."

"The **Winnipeg Medical Association** met on Oct. 4th and elected the following officers: Dr. J. R. Davidson, President; Dr. J. Neil (sic) MacLean, Vice-President; Dr. Vrooman, Secretary-Treasurer . . . at the invitation of the retiring President, Dr. E. W. Montgomery, the meeting adjourned to the Mariagi for dinner." (What, again?)

"Professor Osler, speaking on the subject of the field for women doctors, said the following

were particularly suitable: Children's and Women's Diseases, Medical School Inspectors and the zenana work."

"The Trustees for the Sanitarium for Consumptives of Manitoba have decided to make the location Ninette . . . cost about $40,000 or $50,000. A medical man is to be sent throughout the Province to solicit subscriptions."

"The sewage that flows down Rat Creek into the River is to be freed from disease germs and odor and rendered harmless by a septic tank."

"Dr. Egerton Pope, of Winnipeg, has gone to London, England. He will be absent about a month."

"Dr. Bjornson is acting as Health Officer in the absence of Dr. Douglas, of Winnipeg, who is attending the American Public Health Association Convention at Atlantic City."

"Dr. A. P. W. McKinnon has been appointed Gaol Surgeon of the Central Judicial District Gaol of Manitoba in place of Dr. H. A. Gordon, resigned.

Married—"Hunter-Bouvette—on Sept. 27th, at Winnipeg, Charles Hunter, M.D., of Winnipeg, to Louise Bouvette, late of Dauphin, Manitoba."

The Canadian Northern Railway advertise "The Alberta Express," daily between Winnipeg and Edmonton as "The Correct Route."

Vol. 1, No. 11, for November, 1907, opens with an original article by A. J. Ochsner, B.S., F.R.M.S., M.D., Professor in Clinical Surgery in the Medical Department in the University of Illinois, Chicago. It is entitled, "The Present Clinical Aspect of Stomach Surgery" and was read before the Surgical Section of the St. Louis Medical Society, Oct. 18th, 1907. The author deals at length with the "Difference of Opinion between Internists and Surgeons." His analysis of this problem is not different from that which might be given today—in other words the internists haven't improved a bit!—or should that read, the surgeons are as bull-headed as ever? He asserts that "surgery of the stomach is (now) limited in its results to three conditions:

1. The closure of the defect following perforative ulcer or gunshot or stab wounds, or rupture of the stomach due to traumatism.

2. The establishment of drainage in cases of obstruction of the pylorus due to neoplasms, cicatricial contraction, the presence of indurated ulcer or hour glass stomach in the adult and the presence of congenital stenosis in children.

3. The removal of neoplasms; and possibly

4. The correction of gastroptosis."

He makes no mention of surgical interference in the case of haemorrhage, and some modern observers might acclaim him for this omission.

"A case of Primary Sarcoma of the kidney" is by R. W. Kenny, M.D., Winnipeg."

"Artificial Dilatation of the Cervix" follows, by S. W. Hewetson, M.D., of Pincher Creek, Alta. The author advocates the use of the modified Champetier Balloon in his paper which was read before the Alberta Medical Association, Oct. 11th, 1907.

A strong editorial advocates the inauguration of Medical Inspection of Schools. Montreal was apparently the only city in Canada that had medical inspection but it was stopped because of the expense.

The Annual Meeting of the College of Physicians and Surgeons of Manitoba was held with Dr. W. Rogers in the chair.

"The Saskatchewan Medical Society met at Indian Head, Nov. 7th. The members were entertained by the Indian Head Board of Trade to a banquet, automobile ride and a visit to the Experimental Farm."

"There has been an outbreak of diphtheria among the Galicians at Ridgeville."

An outbreak of bubonic plague in San Francisco had caused great alarm in Vancouver. It is the same outbreak to which Osler was to refer so scathingly in his "Principles" later on. "All vessels arriving at Vancouver and Victoria are closely watched. Vancouver council has paid bountry on over 1,000 rats." "Dr. Loir, a nephew of Pasteur, who was lately appointed Professor of Medicine in Laval, has withdrawn owing to Archbishop Bruchesi refusing to sanction his engagement because of his being sued for divorce."

"The yellow fever record in Cuba for 1907 is the worst for several years."

"It is now 25 years since the foundation of Manitoba Medical College. Of the original incorporators, Drs. Blanchard, Good, Patterson, Jones and Sutherland are still in Winnipeg."

"Dr. A. E. Archer attended the Medical Convention at Edmonton, and also paid a short visit to Fort Saskatchewan."

"Dr. J. A. Gunn has been appointed Medical Superintendent of the Winnipeg General Hospital in succession to Dr. Campbell."

"Dr. Octave Lacroix, R.N.W.M.P., will go north to Churchill as soon as the winter sets in. He is now at Norway House."—What a trip in those days!

"We regret to say Dr. O'Brien of Dominion City, has been suffering from diphtheria, but are glad to know he is progressing favorably."

Born—At Neepawa, wife of Dr. Poole of a son."

One book is reviewed. It is "Human Anatomy," by G. A. Piersol. The reviewer, D. S. MacKay, F.R.C.S., Edin., says, "This is a new work of anatomy . . ." as indeed it then was.

Editorial

J. C. Hossack, M.D., C.M. (Man.), Editor

Remembrance Day

With the passing of the years, Remembrance Day loses more and more of its original significance to an ever-increasing number. There was a time when, on its annual recurrence, there were few who could not see in their mind's eye the clearly etched features of friends who had died in battle, few who did not still hear the echo of their voices.

But time lays a thickening veil over once familiar faces and mutes once well-remembered voices till the straining ear can catch no slightest murmur. So has it been with the dead of the First Great War, and those who followed them in the second conflict are already passing into the misty realm of the half-forgotten. To these Remembrance Day is a memorial less to themselves than to the qualities which they displayed and upon the exhibition of which victory depends, in peace as well as in war.

There are others whose persons came closer to us and whose passing we count in months, not in years. They too showed self-sacrifice, devotion to duty, concern for their fellows. They too were soldiers of a sort for they fought against those things that rob men of their ease, of their functions and of their lives.

Each year sees new gaps made in our ranks and the notice of every fresh one comes upon us as a blow. A question rises to our lips that we would have him answer and then, with a sense of shock, we realize that death has stopped his ears and sealed his lips, and in the pause there comes a picture into our minds. Each name calls forth to each one who hears it a special picture of his own. An incident, a mannerism, a habit, something said or done—these are the substance of what we recall and the essence of what we remember.

Yet the memory of these things will endure so long as memory lasts. Recently while riding in a taxi the driver said he knew me. It would appear that years ago I had been asked to see him by Doctor Andrew MacKinnon. He spoke of Dr. MacKinnon, "He was a fine man," said the driver, "You just knew that all he wanted to do was to help you, that he wasn't just after your money. He was a good doctor and a good man and I'll never forget him."

Our colleagues who have died this year will in like fashion be remembered by more than any of us can think. De mortuis nil nisi bonum is our instruction yet it is rarely needed, for somehow it is of the good and generous and kindly things that we prefer to think and speak when our thoughts turn, as they must do now, to those whose day is over and whose task is done.

Armstrong, George Perry, Portage la Prairie
Bell, Percy George, Winnipeg
Campbell, Edgar Alexander, Winnipeg
Cuddy, Thomas Hughes, Winnipeg
Day, Oswald John, Winnipeg
Gibbs, Walter Henry Gabriel, Selkirk
Gilmour, Clifford Rogers, Winnipeg
Harvey, Howard, Winnipeg
Herschman, Hans, Winnipeg
Howden, William Alexander, Neepawa
Kenny, Richard Wellington, Winnipeg
Kippen, Robert, Newdale
Margolese, Oscar, Winnipeg
McDiarmid, Henry Oliver, Brandon
Olin, Gerald Michael, Winnipeg
Olson, Baldur Haroldson, Winnipeg
Sedziak, Francis, Elie
Stewart, John Smith, Newdale
Swan, Robert Rennie, Winnipeg
Williams, David R., Winnipeg
Winram, Alexander Robert, Winnipeg

To most of our colleagues death came swiftly and their agony was short. Such is the boon which we all must crave, for:

"Is not short pain well borne that brings long ease,
"And lays the soul to sleep in quiet grave?
"Sleep after toil, port after stormy seas,
"Ease after war, death after life,
"Doth greatly please."

Winnipeg Medical Society

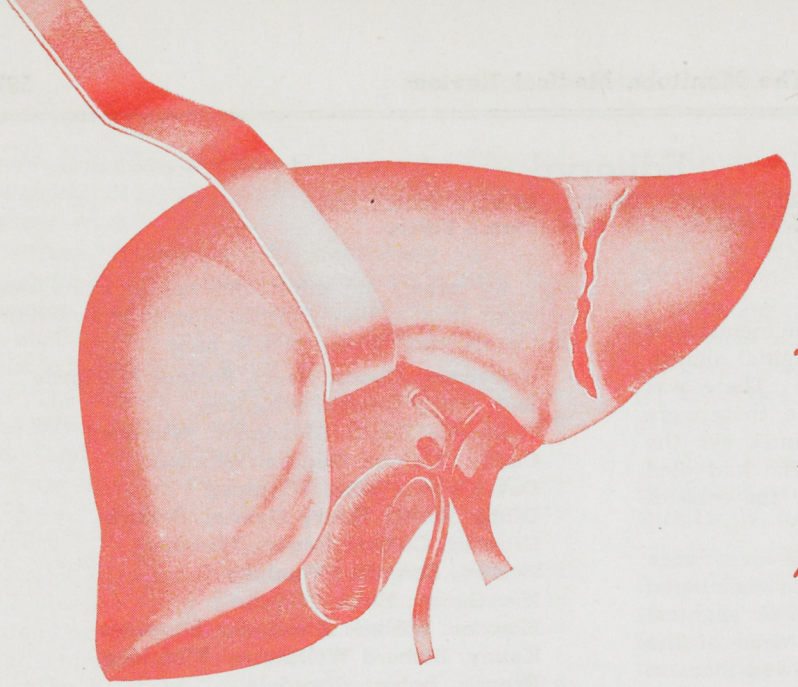
The first meeting of the 1952-53 season was held in the Medical College on the 19th of September. The Society was privileged to hear two speakers, both eminent radiologists, who were en route to the British Columbia Cancer Institute Treatment Centre in Vancouver.

The first speaker, Sir Francis Cade, K.B.E., C.B., F.R.C.S. (Eng.), M.R.C.P. (Lond.), Surgeon to the Westminster Hospital, England, spoke on "The Use and Abuse of Radium as a Therapeutic Procedure."

The second, Professor B. W. Windeyer, F.R.C.S. (Eng.), D.M.R.E. (Camb.), F.F.R., Chief of the Meyerstein Institute of Radiotherapy, Middlesex Hospital, London, spoke on the subject, "Leukemias."

There was some considerable discussion of both papers later in the evening.

This meeting was particularly well attended,



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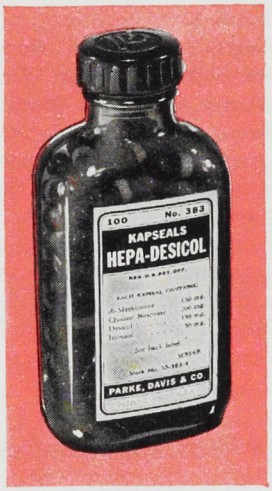

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HEPA-DESICOL combines choline, methionine, and inositol with Desicol (desiccated whole fresh bile, Parke-Davis). It is valuable in the treatment of liver dysfunction often accompanying early cirrhosis, alcoholism, diabetes mellitus, malnutrition, obesity, and atherosclerosis.

Lipotropic action of choline, methionine, and inositol is well established; Desicol not only provides additional bile but also stimulates normal bile flow. This dual action of HEPA-DESICOL provides more effective therapy of disturbed fat metabolism.

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each Kapseal contains:

dl-Methionine	150 mg.
Choline Bitartrate	200 mg.
Inositol	50 mg.
Desicol®	150 mg.

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and perhaps set some sort of record for length and it was not adjourned until 11.45 p.m.

The matter of meetings running too late in the evening, was under consideration by the Executive of the Winnipeg Medical Society at an earlier meeting, and it is understood that most of the future meetings have but one main paper.

Civil Defence Course

The Department of National Health and Welfare, Civil Defence, announces that they propose to continue with the training of doctors in Atomic, Biological and Chemical Warfare Defence. Courses will be held:

24 - 28 November, 1952

2 - 7 March, 1953

Any doctor interested in taking the course, please contact Dr. Hugh Malcolmson, Dept. of Health and Public Welfare, Winnipeg.

The Farmer Has Three Wives

The August-September number contained a paper by Dr. H. Medovy on the care of premature infants. In this he gave three formulae in which "Farmer's Wife" Milk was used.

Apparently some confusion has arisen because the formulae were marked F.W. 1, F.W. 2, F.W. 3 instead of (what would have been better) Formula 1, 2, 3. The cause of confusion lies in the fact that "Farmer's Wife" Milk is sold in three strengths, also numbered 1, 2, and 3. The three wives, it would seem, differ among themselves in the amount of cream their milks contain. Wife Number Two is the one favoured by Dr. Medovy and the three formulae are based on her milk. In other words the same milk (Farmer's Wife Number Two) is used in all three formulae.

(Farmers who collect wives should refer to them by name and not by number—it would be much less confusing).

Book Reviews

Research in Endocrinology, by August A. Werner and Associates. Edited by Al. R. Schmidt, City Editor, Belleville Daily Advocate, Belleville, Illinois.

It is unusual for the editor of a city newspaper to undertake the editing of a scientific work but so it is here.

It is not clear to what extent the book is by, as well as about, Dr. Werner. It is written throughout in the third person but Dr. Werner himself signs his acknowledgments to various people for "constructive and helpful assistance."

Chapter I details the academic appointments which he has held, the societies to which he belongs, his hospital affiliations, his publications and the titles of lectures he has given.

In 1922 he became associated with the Englebach Clinic and the following year established an Endocrine Clinic at the St. Louis City Hospital. This he attended three afternoons each week for two hours at a time during which period he saw an average of 100 patients each afternoon. In addition to these duties he had others resulting from his attachment in an attending or consulting capacity, to five institutions with over 10,000 inmates or patients. He also instructed in the Medical School and had staff duties in the City Hospital.

Despite the very full days which such employments would occupy he found time to write 52 scientific papers, a text book on endocrinology, and special chapters in books by other authors, and to deliver 79 lectures before various scientific bodies. From all this it becomes obvious that he had not only an enormous appetite for work but also a tremendous capacity for it.

Werner's original work and the advances for which he was responsible are summarized in Chapter 2. They are set forth as Research Problems and are numbered 1 to 9.

Problem 1 is entitled "The Hypo-ovarian Syndrome." Werner was the first to "evaluate the significance of, and to crystallize into a syndrome" the "complete group of symptoms characteristic of a function of hypo function of the ovaries." This was in 1931. Problem No. 2—"Climacteric Psychosis"—led him to conclude that estrone would be helpful in treatment and this he proved by the use of Theelin which thereafter was widely adopted.

"The Male Climacteric" formed his third problem and he found a solution for its discomforts in testosterone. He was not the first to use testosterone but probably was the first to give a clear account of the syndrome of the climacteric in the male.

The next four problems concerned the actions of Theelin in castrate women. The eighth problem was what could be done for cryptorchidism. It was Werner's idea that a gonadotropic extract of the anterior pituitary would remedy this condition and the substance known as Antuitrin S was prepared at his request. In practice he found his theories confirmed.

Chapter 3 tells How the Research by Werner and his associates was accomplished—a sort of taking the reader behind the scenes to watch research in action.

Chapter 5 is a reprinting of sixteen of his papers. These papers are the crucial ones concerning the problems. Their arguments have long

since been accepted or modified but there they are, the original communications, easy of reference.

The fourth chapter I have left to the last. It is biographical and, in a way, is the best part of the book; for the scientific papers reveal only a small section of medical progress while the biography illustrates how alone progress can be made in any field.

Werner was born of mixed ancestry in 1883. Apparently his schooling was slight but, in school or out of it, he had learned habits of dilligence and integrity, and had acquired a desire for knowledge and a sense of responsibility. With such habits and acquisitions early established it was necessary only to have ambition and a goal to be certain of success.

He was variously employed from the time he was 15 until he was 21 when he became a Postal Clerk at $50.00 a month for a 70-hour week. A year later he was advanced in status and in salary and in two years had saved $1,300. He spent his leisure in general reading and in "special studies" so that, in 1907, he was able to enter the St. Louis School of Medicine from which he graduated in 1911. He had to rely on his own resources and consequently sought work both during and between terms. This was not without advantage for during two of the four years he demonstrated anatomy and physiology and thereby not only earned his tuition fees but learned as well. With his time so fully occupied Werner appreciated its value and filled "each unforgiving minute with sixty second's worth of distance run." He studied methodically for four hours every evening except on Saturday when he spent ten hours at his books and on Sunday when he spent thirteen hours.

Despite his industry and thrift he left college in debt. But, having now his license he entered practice in a small village. At the time doctors were many and patients were poor. For fifty cents he supplied advice (and medicine) to those who came to his office. A house call in town was worth an extra half-dollar. When it was necessary to visit patients out of town the fee was two dollars for five miles with, of course, free medicine. As an obstetrician he could charge $10.00 (however long or difficult the case) unless the baby arrived first in which case the infant started life by saving his parents $5.00.

His most profitable year enriched him by eighteen hundred dollars out of which five hundred went for medicine and four hundred for the care of his horses. The prospect of making $75.00 a month would scarcely lend glamour to the youth who yearns today to be a doctor; nor, even then, was the outlook particularly rosy.

He was 39 when be became attached to the Englebach Clinic. Englebach told Werner that he would be glad to have him as his assistant but without pay. Many would have given no second thought to such a one-sided arrangement, but Werner was not only industrious, he was wise. No one who was so conscious of the value of Time could be oblivious to the value of Opportunity. No one who had taken such pains to instruct himself would other than welcome the chance to gain instruction from an eminent teacher. He accepted the offer. Out of his earnings as a practitioner he had managed to save three thousand dollars and on this he and his family lived for the next two years.

After he left the Englebach Clinic in 1924, he began his years of research all of it done without remuneration. His work gave him pleasure but not satisfaction, for the solution of each problem seemed to leave him on the threshold of another which also had to be solved before the work could be called complete.

Werner seems to have had a vocation only. There is no hint of relaxation or play. But at times he would meditate on the past and on one such occasion the words came to him "Ambition, enchantress of youth." "What a beautiful line for the beginning of a poem," he thought. He had never written a poem before but there has to be a first time for everything so he got to work. After twenty minutes of cogitation he had on paper six verses of four lines each. Apparently he did not feel with Milton (Alas, what boots it with uncessant care to strictly meditate the thankless Muse) for Werner's Muse appeared promptly. But she was a limping ataxic wench whose feet were constantly getting tangled up, so that any resemblance between her efforts and real poetry are purely accidental.

The Muse assailed him a second time with no happier results and then on "the following Sunday Dr. Werner wrote the third and last" of his attempts and in so doing desecrated the Lord's Day by perpetrating one of the worst "poems" ever written on any day! Werner's prose is much better than his verse and his facts are much more valuable than is his fiction.

The biographical part ends with "Five Tenets for Success." 1. Health. 2. A good average mind. 3. An intense desire for successful accomplishment. 4. Willingness to sacrifice without quitting to the end. 5. An inflexible spirit of truth and honesty. No one will disagree with him there.

Although the matter in the scientific portion of the book is now common knowledge yet it is interesting to review the development of valuable research. But the biographical part is the most interesting for it shows how essential are the basic qualities of imagination, intelligence and perseverance. Without them nothing can be accomplished; with them everything can be overcome. Indeed the value of the book lies chiefly in its ability to inspire ambitious youths to do as Werner has done.

Social News

Reported by K. Borthwick-Leslie, M.D.

The boys are really doing well and making the news headlines. Congratulations and good wishes for all and one.

♦

Dr. R. A. McPherson, associate professor of radiology in the U. of M. Faculty of Medicine, has been promoted to professor and chairman of the Department. He succeeds Dr. Digby Wheeler who recently retired from the post.

♦

Lt.-Col. C. G. Wood, O.B.E., Command Medical Officer, Prairie Command, is now Col. C. G. Wood —"full red tab wolf, I believe they are tagged." Col. Wood received his degree in Science and Medicine from the U. of Man.

♦

Dr. C. W. Wiebe, Winkler, Man., succeeds Dr. A. M. Goodwin as the new President of Manitoba Medical Association for the coming year. It's a tough assignment Doctor!!

♦

Dr. Harry Medovy is now the Director of Child Health Services for Winnipeg. Harry succeeds the late Dr. O. J. Day. Fame apparently is fame. Overheard one of our junior men being labelled as a Children's Specialist the other morning—all because he wore a cute bow tie!!

♦

Dr. W. Donald Ross, graduate of U. of M. has been named professor and head of the Department of Psychiatry of the University of B.C. Dr. Ross took his Post Graduate work in Psychiatry at McGill and served on the staff of the University, Cincinnati.

♦

Seven federal health bursaries have been awarded to local boys. Dr. M. E. Bristow, Brandon, bursary for 1 year's study in Neuropsychiatry, University of Pennsylvania. Drs. D. L. Scott, S. L. Carey, The Pas; W. Zajcew, Ninette; J. A. MacDonnell, Winnipeg, all to Toronto Hospital for Tuberculosis, for courses in the prevention, diagnosis and treatment of T.B. The 7th bursary goes to E. Singleton, statistician.

♦

Dr. and Mrs. E. T. Etsell have returned from an extensive tour in Britain and the Continent. While Dr. Etsell studied in London, Mrs. Etsell studied French, Spanish and modern music in Paris.

♦

Dr. and Mrs. W. D. Bowman and son sailed in late September on the Empress of France for England where Dr. Bowman will do P.G. work in pediatrics at Newcastle, Yorkshire, on a Nuffield fellowship.

♦

Dr. and Mrs. Bruce Chown and Dr. and Mrs. Wallace Grant have as their guests Dr. and Mrs. W. M. Grant who will make their home in Winnipeg. Dr. Grant was formerly pastor of Crescent Fort Rouge United Church, and recently Assistant Pastor of Erskine United Church, Toronto.

♦

Holy Trinity Church was the scene Sept. 6th when Shirley Ann Thompson became the bride of Dr. Kenneth Browell Duncan. Dr. and Mrs. Duncan will reside in Moose Jaw.

Fort Osborne's St. Andrew's Chapel was the scene of a colorful Military Wedding when Capt. Mary Alexa Swan, C.W.A.C., daughter of the late Dr. and Mrs. Alex Swan, became the bride of Major Albert E. Adams, R.C.A.

♦

Oct. 25, the wedding of Shirley Anne Gompert and Dr. John Gerald Fox, son of Dr. and Mrs. R. G. Fox, Winnipeg, took place in Los Angeles. Dr. Fox, Jr. is a graduate of Manitoba Medical College.

♦

Dr. and Mrs. T. H. Williams, Duffield St., announce the engagement of their daughter Helen Anne to Wm. Earl Shepherd, only son of Mr. and Mrs. W. H. Shepherd. The wedding will take place Nov. 21, in Young United Church.

♦

It is with regret and smpathy to the friends and relations that we announce several deaths:

The saddest, that of Dr. J. E. Lamb, 30, who died after a brief illness. A 1952 graduate of Manitoba Medical College, Dr. Lamb was taking a Post Graduate course in Pathology under Dr. Nicholson.

Dr. B. H. Olson, 64, former medical director of the Great West Life Insurance Co., died after a prolonged illness at Deer Lodge Hospital.

Dr. G. Crane, graduate of the U. of M., Chief Pensions Examiner for D.V.A. in Regina, and former Liberal Member of the Sask. legislature, died in Regina.

Dr. J. S. Stewart, 88, formerly of Newdale, Man., died in Winnipeg recently.

Dr. A. R. Taylor, 74, formerly in charge of Deer Lodge Hospital, died in Shaughnessy Military Hospital, Vancouver.

♦

To the newcomers—Welcome.

Dr. and Mrs. J. M. Huot happily announce the birth of their son, Sept. 19th.

♦

Dr. and Mrs. Quenton Jacks, Rochester, Minn., announce the birth of their fourth son, Oct. 11th, in St. Mary's Hospital, Rochester.

♦

Dr. and Mrs. Norman O. Smith, Yonkers, N.Y., announce the birth of Stephen Housley, on Sept. 19, in Yonkers.

♦

Dr. and Mrs. S. Bellan are happy to tell the world of the arrival of their first born, a son, Sept. 29th.

♦

Dr. and Mrs. Thomas Dingle are happy to announce the arrival of Barbara Jean, Oct. 5th.

♦

Dr. and Mrs. Paul Adams announce the birth of their second daughter, Frances Louise, Oct. 9th.

♦

Dr. and Mrs. J. H. Crust, Oakenwald Ave., announce the birth of Louis Jonathon, brother for Carole and Gail.

♦

Dr. and Mrs. J. M. McMahon announce the arrival of Elaine Joyce, Oct. 6th.

♦

Dr. and Mrs. Gordon J. Smith announce the birth of a son, Gordon Edward, Oct. 6th, at Gladstone, Man.

♦

Dr. and Mrs. A. J. Alcock are pleased to announce the arrival of a daughter, Oct. 29th.

♦

Dr. and Mrs. Paul Rosen announce the birth, in Chicago, Ill., of Andrea Greer.

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- *Efficient.....*
- *Palatable.....*

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Sodium Citrate	16 grs.
Sodium Bromide	8 grs.
Tincture Ipecac	12 mins.
Syrup Tolu	80 mins.
Syrup Wild Cherry	32 mins.
Mentholated Honey and Linseed	q.s.

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1952
COMMITTEE REPORTS

Manitoba Medical Association
(Canadian Medical Association, Manitoba Division)

Executive

To the Executive Committee and Members of The Manitoba Medical Associations

I.

History has been called the methodical record of past events, and since the Chairman of each Committee will report on the activities of the current year, history is about to be made. It is necessary here to record only the highlights of a year which has been both busy and profitable.

2.

The last Annual Meeting had hardly been concluded before arrangements were made for the Forty-fifth Annual Meeting to be held at the Royal Alexandra Hotel, Winnipeg. The Scientific Programme Committee under the co-chairmanship of Dr. A. T. Gowron and Dr. J. C. Hossack was reappointed, and has worked diligently to produce a satisfactory program. Dr. Harold Orr, President, and Dr. A. D. Kelly, Deputy General Secretary, of the Canadian Medical Association, will be accompanied by Doctors John W. Scott, Edmonton, and C. M. Spooner of Toronto, while other expected speakers will include Dr. Norman Miller, Ann Arbor, Michigan; Dr. Max Thorek, Chicago; Dr. Frank B. Walsh, Baltimore, Maryland. Luncheon speakers will include Mr. Carlyle Allison, Dr. Harold Orr, Professor R. A. Wardle, Inspector J. A. Churchman, R.C.M.P.

3.

In addition to the eight formal meetings of the Executive Committee, at which an average of seventeen persons sat for three hours per session, twenty-five committees met periodically. The President, Executive Secretary and Honorary Secretary are ex-officio members of all committees and attended whenever possible. To each and every one, including members and others, who assisted in the discussions of Civil Defence, Manitoba Medical Service, Radiologist Bill, Trans-Canada Medical Service, Workmen's Compensation Board, and many other matters, sincere appreciation is expressed.

Office Accommodation and Staff

4.

Since attempts to secure additional office space were unsuccessful, remodelling of present quarters was undertaken. In this way it was possible to house the staff and to retain office space for the Review. Purchase of the Apex Building on Osborne Street, adjacent to the new Manitoba Medical Service Building, was considered in conjunction with the College of Physicians and Surgeons but was postponed indefinitely.

Miss H. M. Brown. Assistant to the Executive Secretary, who so capably and willingly carries out the many duties of Secretary, Office Supervisor and Bookkeeper, deserves special mention. During the periods of personnel changes, her duties have been carried through with customary efficiency. Two junior members of staff are gradually assuming increased responsibility, and will be of great assistance in the busy year which lies ahead.

Canadian Medical Association

5.

The 1952 Annual Meeting of the Canadian Medical Association was held at Banff in June. In addition to the President and Secretaries, this Division was represented on General Council by Doctors B. D. Best, E. F. E. Black, C. W. Burns, Evjolfur Johnson, R. Lyons, Jack McKenty, W. F. Tisdale, C. W. Wiebe. Decision to participate in the arrangements for hospital accreditation and of Trans-Canada Medical Services were two of the factors of rising costs which necessitated an upward revision of the membership fee. A more detailed account of the Banff activities was circulated to members through the mail, the Manitoba Medical Review, August-September, 1952, and the Canadian Medical Association Journal for September, 1952. Dr. Ross B. Mitchell was elected to Senior Membership, and Dr. C. W. Burns was named President-Elect. A symposium based on "The High Cost of Being Sick," which appeared in Maclean's Magazine for June, was a popular feature of the evening session on Thursday, June 12th, when members of the panel included Doctors A. D. Kelly, Chairman, Dr. E. F. E. Black, Dr. Norman Gosse, Dr. J. A. McMillan, Mr. Sidney Katz, author of the article, Dr. Gordon Johnston, Mr. Kenneth McTaggart. During the week of June 15th, 1953, the Manitoba Division will be host to the next Annual Meeting of the Canadian Medical Association and will be entitled to name two senior members.

Advisory Committee Under the Health Services Act

6.

Dr. D. L. Scott was named to replace Dr. A. Hollenberg who had served two consecutive three-year terms and who was ineligible for a further period of service until an interval of one year had elapsed.

Canadian Arthritis and Rheumatism Society

7.

Sympathetic support was given to the Manitoba Division in connection with the annual campaign for funds, but difficulty was encountered in assessing the extent to which the recommendations of the Canadian Medical Association General Council, 1951, might be implemented for the care of arthritics.

Civil Defence

8.

Discussion of the role of the medical profession and preliminary organizational work occupied the attention of the Executive Committee at several sessions. Dr. K. C. Charron, Ottawa, and Dr. H. Malcolmson interviewed the Committee. District Medical Societies were circularized and the Winnipeg Medical Society Committee held meetings to survey the problem. Two meetings of the Provincial Advisory Committee were attended by the Executive Secretary, who also participated in the regional conferences at Kingston and Regina. A request from the Provincial Attorney-General for a medical man to serve full time for a short-term assignment was suitably filled through the Association office. A request of the Manitoba Division, Canadian Red Cross, to nominate a chairman of Medical Committee for Disaster Services was deferred.

District Medical Societies

9.

All were active during the year including one combined meeting which was held at Clear Lake on June 25th to which members of four Societies were invited. All meetings were attended by the President and/or the Executive Secretary, and it was a great privilege to see the groups in action and to share the enthusiasm with which the sessions were conducted.

Ethics

10.

The Canadian Medical Association Committee on Ethics approved acceptance by a member of the Manitoba Division of an invitation to become a guest editor for a projected publication of a book of health intended for distribution to the public.

A reference to the corresponding committee of this Division concerning the use of professional cards in foreign language newspapers is still under discussion.

Endorsation Committee of Medico-Lay Organizations

11.

In 1951 General Council requested the Canadian Medical Association Executive Committee to appoint a special body to advise upon the worthiness of appeals for public funds which relate to medical care. Following legal opinion, however, the matter was referred back to the provincial divisions for action. In Manitoba such a committee has been operative for some time and includes individual members of the profession.

Fee Taxing Committee, Workmen's Compensation Board

12.

This Committee was called to meet almost monthly. Three practising physicians were selected from an available panel of five members, and the evening sessions were held in the office of the Chief Medical Officer. As many as a dozen cases were reviewed at one session and a fee recommended which was usually accepted by the Board. In some cases the doctor appealing an assessment appeared before the Committee.

General Practice

13.

A request for nomination of one representative to the Canadian Medical Association Section on General Practice was referred to the General Practitioners' Association, and the nomination was approved.

Health Survey

14.

In June, 1951, a copy of the Interim Report was forwarded to the Association for comment, but it remained for the medical members to discuss the Report in its final form. Highlights were carried in the Winnipeg papers on Friday, September 12th, but no copy has yet been received by the three representatives of the Association.

Income Tax

15.

Notice was received from the Taxation Branch that the ruling applicable to partnerships had been reversed, and that expenses of the partners necessary to earning the livelihood, and not allowed prior to the division of proceeds, might be deducted from personal returns.

Legal opinion was secured concerning the right of examiners of income tax returns to remove documents, including case histories, from the physician's office and the removal of patient files from the hospital records.

No provision was made for income tax deductions for postgraduate study or for contribution to pension schemes by self-employed individuals.

Manitoba Medical Review

16.

Another successful year was recorded, marked by a grant to provide for illustrations of papers given by various speakers, and a review of the financial arrangements.

Manitoba Medical Service

17.

Since the inauguration of the Service, medical members have been nominated by the Association and named to the Board of Trustees. In 1950 the Executive Committee reserved the right to name one member of the Committee on Economics to the Board of Trustees and this was accepted by the Annual Meeting. The prerogative was not exercised in 1951 since one member selected by ballot was also a member of the Committee on Economics. In 1952, however, in order to retain the services of certain valuable members, the Board of Trustees enlarged itself by continuing five members in office for one year. It is anticipated that the Chairman, Dr. P. H. McNulty, and the Treasurer, Dr. C. E. Corrigan, will be present during the evening business session to bring the members up-to-date on the activities of the Service.

Medical Education

18.

The Association indicated willingness to co-operate with the Faculty of Medicine to provide speakers for meetings of the final year to discuss matters of interest to graduating students.

Approval was also given to trial radio broadcasts over the CBC network such as were carried out several years ago.

Medico-Legal Society

19.

Previously recommended from discussions between the Canadian Bar and Medical Associations, steps were taken one year ago, in conjunction with the Law Society of Manitoba, Manitoba Division of the Canadian Bar Association and the College of Physicians and Surgeons, for the establishment of a Medico-Legal Society which will bring members of each profession together on four occasions during the year. Good sessions were reported.

Membership

20.

Notice of motion was approved that those who change employment status within six months after paying a lower fee should contribute the full membership fee. Concessions were made for those who served outside Canada with the Armed Forces, as for those, who by reason of advanced age or incapacity, were not actively engaged in practice. In spite of the increased fee and some withdrawals, the membership figure stands at an all-time high.

Public Relations

21.

Visits were made to two districts where problems had arisen between the community, hospital and physicians. The Association was represented at the Annual Meeting of the Canadian Public Health Association, and the opening of the new Morden District Hospital. Unfortunately a similar invitation to attend the opening of the new Virden Hospital was not possible but greetings were relayed on that occasion by a past-president of the Association and confirmed by wire.

Radiologists-Incorporation

22.

A special committee was set up one year ago after the proposed bill of incorporation was withdrawn. Information secured from provincial divisions and representative radiological groups was examined, and the recommendation was that the Association should not oppose the bill. When, however, word was received that it might not be favourably considered by the Legislature, the Bill was withdrawn by the Radiologists until conditions were more favourable.

Society for Crippled Children of Manitoba

23.

The Association has been represented since the inception of the Society on the Board and Medical Advisory Committee. Members have assisted with the survey, and definitive treatment has been undertaken on the basis of an arranged fee or honorarium.

Specialist Register-College of Physicians and Surgeons

24.

During the year notification was received from the licensing body that a Specialist Register would be set up in the Province. Basic qualification is Fellowship or Certification of the Royal College of Physicians and Surgeons of Canada, but a committee of six, including two members named by this Association, will consider until Dec. 31st, 1952, application of any doctor claiming specialist status who presents the required evidence.

Vacancies for Medical Practitioners

25.

By means of the Professional Registry, contact has been made with medical men seeking locations, and districts,

municipalities, towns or villages seeking a physician. Contact was made with the Department of Health and Public Welfare early in the new year when it was realized that there were not nearly enough suitable vacant locations in the Province to attract the members of the 1952 graduation class in medicine who had expressed a desire to remain in Manitoba. Lists were made available by the Department to each member of the final year, and the Honourable Minister of Health informed the Legislature of the improved situation. The number of younger physicians in rural practice has increased significantly during the past year.

The Workmen's Compensation Board

26.

This one item received more attention from the Executive Committee than any other individual matter during the year. There were numerous meetings of the W.C.B. Negotiating Committee, and two full sessions of that body with the Board. Discussions were held between the Negotiating Committee and the Executive Committee on five occasions; brochures and letters were sent to all members. The Negotiating Committee will report a happy solution to the problem which has heretofore been perennial.

A, M. Goodwin,
President.

F. G. Stuart,
Honorary Secretary.

Honorary Treasurer

To the President and Executive of
The Manitoba Medical Association:

27.

Herewith certified financial statement from our auditors, Messrs. Thornton, Milne and Campbell, for the year 1951, also supplemental statement, prepared by the Association office, to August 31st, 1952:

10th March, 1952.

To the Members,
Manitoba Medical Association,
Winnipeg, Manitoba.

Dear Sirs:

We have examined the Statement of Assets and Liabilities of the Manitoba Medical Association as at 31st December, 1951, and the Statement of Revenue and Expenditure for the year ended on that date. Our examination included such tests of accounting records and other supporting evidence as we considered necessary in the circumstances and we have obtained all the information and explanations we have required. We submit herewith the undernoted financial statements:

EXHIBITS:

"A" Statement of Assets and Liabilities as at 31st December, 1951.

"B" Statement of Revenue and Expenditure for the year ended 31st December, 1951.

The operations for the year, as set forth in Exhibit "B," have resulted in an excess of Expenditure over Revenue of $1,823.56. Membership fees collected are in accordance with duplicate receipts on file and were reconciled with membership cards issued. The Association also received the customary sums, covering applicable portions of the general office expenses, of $75.00 per month from the Winnipeg Medical Society, and $200.00 per month from the College of Physicians and Surgeons until 1st October, 1951, at which time this amount was reduced to $80.00 according to the terms of the revised agreement. All expenditures have been properly authorized.

Relative to our examination of the various items comprising the Statement of Assets and Liabilities, marked Exhibit "A," we have the following comments to make.

CASH ON HAND AND IN BANK, $2,449.43: We did not count the cash shown to be on hand. Subject to an allowance for outstanding items as revealed by the books, the amount shown to be on deposit is in agreement with a certificate received from your Bankers.

ACCOUNTS RECEIVABLE, $952.83: All accounts receivable are considered to be collectible in full.

INVESTMENTS, $10,072.12: We examined the Bonds and found them to be in order, duly registered in the name of the Association. During the year your holdings were increased by the acquisition of $2,000.00 Province of Manitoba 3% 1968 bonds at a cost of $1,965.00.

All bond interest has been duly accounted for, on a received basis, in the accounts of the Association.

Subject to the foregoing comments, we are of the opinion that the accompanying Statements of Assets and Liabilities, and of Revenue and Expenditure are properly drawn up so as to exhibit a true and correct view of the state of the affairs of the Association as at 31st December, 1951, and the result of its operations for the year ended on that date, according to the best of our information, and the explanations given to us and as shown by the books of the Association.

In conclusion we wish to express our appreciation of the co-operation given us during the course of our work.

Yours very truly,
THORNTON, MILNE & CAMPBELL,
Chartered Accountants.

Exhibit "A"

28.

Statement of Assets and Liabilities
As at 31st December, 1951

ASSETS

Current Assets:			
Cash:			
Petty Cash on Hand	$ 20.00		
Bank of Montreal	2,429.43		
		$ 2,449.43	
Accounts Receivable:			
Review Advertisers	$ 794.88		
College of Physicians and Surgeons:			
Extra Mural Expenses	$103.05		
Fee Taxing Committee—Workmen's Compensation Board	40.00		
	143.05		
Sundry	14.90		
		952.83	
			$ 3,402.26
Investments:			
(Market Value, $9,625.63)			
	Par	Cost	
Province of Manitoba:			
4½% 1956	$ 2,000.00	$ 1,957.12	
3% 1968	2,000.00	1,965.00	
Government of Canada:			
3% 1957	1,000.00	1,000.00	
3% 1959	500.00	500.00	
3% 1963	500.00	500.00	
3% 1966	4,000.00	4,150.00	
			10,072.12
Office Furniture and Equipment		2,004.95	
Less: Reserve for Depreciation		2,004.95	
Prepaid Expenses:			
J. G. Whitley Advance—re Man. Medical Review	200.00		
Less: Account Payable—J. G. Whitley	51.69		
		148.31	
Office Remodelling		5.00	
			153.31
			$13,627.69

LIABILITIES

Current Liabilities:		
Accounts Payable, Canadian Medical Association	$ 40.00	
Fees Collected in Advance	30.00	
		$ 70.00
Surplus Account:		
Balance as at 31st December, 1950	$15,381.25	
DEDUCT: Excess of Expenditure over Revenue, as per Exhibit "B"	1,823.56	
		13,557.69
		$13,627.69

Exhibit "B"

29.

Statement of Revenue and Expenditure
For the year ended 31st December, 1951

REVENUE

Fees Collected:		
497 Members at $25.00	$12,425.00	
2 Members at 12.50	25.00	
113 Members at 5.00	565.00	
2 Members at 2.50	5.00	
46 Members at 10.72	493.12	
27 Members at 5.36	144.72	
5 Members at 22.00	110.00	
10 Members at 2.00	20.00	
702	$13,787.84	
ADD: Sundry Fees, 1950	51.64	
		$13,839.48
College of Physicians and Surgeons		2,040.00
Winnipeg Medical Society		900.00
Interest on Bonds	310.77	
ADD: Premium on U.S. Funds	1.33	
		312.10
		$17,091.58

EXPENDITURE

Salaries:		
Dr. M. T. Macfarland	$4,800.00	
H. M. Brown	2,612.50	
L. G. Johnson	953.50	
L. Zawadski	494.00	
J. Allison	1,035.00	
B. J. Wright	1,111.75	
O. Slonecki	179.00	
		$11,185.75
Expense Allowance—Dr. Macfarland		1,200.00
Honorarium—Dr. Hossack		1,500.00
Rent		1,543.20
Printing, Postage and Stationery		423.38
Office Furniture and Equipment		893.79
Telephone and Telegraph		257.84
Miscellaneous Expense		180.15
Business Taxes		132.18
Audit Fees		100.00
Light		57.33
Bank Charges		6.63
Machine Servicing		39.72
Legal Expense		60.00
Subscriptions		96.28
Transcription of Records		3.75
Office Expense		77.35
Unemployment Insurance		76.20
Travelling Expense		250.25
Donations		315.00
Entertainment		49.40
Executive Luncheons		37.30
Annual Meeting	$2,747.14	
LESS: Rental of exhibit space	2,317.50	
	429.64	
		$18,915.14
DEDUCT: Excess of Expenditure over Revenue for the period		1,823.56
		$17,091.58

30.

Supplemental Statement of Assets and Liabilities
January 1st to August 31st, 1952

ASSETS

Cash:		
Petty Cash on Hand	$ 20.00	
Bank of Montreal	16,058.47	
		$16,078.47
Accounts Receivable:		
Review Advertisers	$ 1,190.04	
J. G. Whitley—Advance Travelling	275.00	
College of Physicians and Surgeons:		
Extra Mural	$ 416.10	
Fee Taxing Committee, W.C.B.	140.00	
Miscellaneous	6.38	
	562.48	
		2,027.52
Investments		10,072.12
		$28,178.11

LIABILITIES

Accounts Payable:		
Dr. J. C. Hossack, Honorarium		$ 1,000.00
C.M.A. re Membership Fees collected		12.50
Deferred Income:		
Annual Meeting, Exhibitors' Deposits		3,192.50
Surplus Account:		
Balance as at December 31st, 1951	$13,557.69	
Add:		
Excess of Revenue over Expenditure	10,415.42	
		23,973.11
		$28,178.11

31.

Statement of Revenue and Expenditure January 1st to August 31st, 1952

REVENUE — COMPARISON

FEES COLLECTED:	1952			1951			1950		
	493 Members	@ $40.00	$19,720.00	490 @	$25.00	$12,250.00	487 @	$25.00	$12,175.00
½ year @ $40.00	4 Members	@ 20.00	80.00	2 @	12.50	25.00	2 @	12.50	25.00
	97 Members	@ 15.00	1,455.00	105 @	5.00	525.00	103 @	5.00	515.00
½ year @ $15.00	1 Member	@ 7.50	7.50	1 @	2.50	2.50	4 @	2.50	10.00
Recent Graduates	49 Members	@ 20.00	980.00	45 @	10.72	482.40	39 @	10.72	418.08
Recent Grad., ½ year	27 Members	@ 10.00	270.00	20 @	5.36	107.20	5 @	5.26	26.80
Combined Fee H. & W.	6 Members	@ 37.00	222.00	5 @	22.00	110.00	6 @	22.00	132.00

Combined Fee H. & W.	2 Members	@	12.00	24.00	3	@	2.00	6.00	1 @ 2.00	2.00
									2 @ 4.97	9.94
	679			$22,758.50	671			$13,508.10	1 @ 2.00	2.00
Plus Arrears, 1951				50.00	Plus 6 Non-Resident				1 @ 7.50	7.50
6 Non-Resident Fees		@	$2.00	12.00	Members	@	$2.00	$ 12.00	651	$13,323.32
					Plus 1950 Arrears			57.00	Plus 1949 Arrears	38.50
					Less 1 1951 paid 1950			5.36	Plus Refund C.M.A.	10.00
								51.64	Plus Foreign Exchange	1.50
				$22,820.50				$13,571.74		$13,373.32

Brought Forward from Fees	$22,820.50
College of Physicians and Surgeons	1,422.50
Winnipeg Medical Society	600.00
Interest on Bonds	127.50
Secretarial Services to Post Graduate Committee	24.00
	$24,994.50

EXPENDITURE

Salaries:		
Dr. M. T. Macfarland, including expense allowance	$4,000.00	
Miss H. M. Brown	1,840.00	
Miss Lorna Zawadzki	950.00	
Miss Eleanor Worster	262.50	
Miss Shirley Hughes	135.50	
Miscellaneous former employees	800.25	
		7,988.25
Honorarium, Dr. J. C. Hossack		1,000.00
Unemployment Insurance		49.56
Office Remodelling		1,904.18
Rent		1,118.40
Printing, Postage and Stationery		684.81
Office Furniture and Equipment		95.60
Telephone		285.20
Business Tax		149.43
Audit Fee		100.00
Executive and other Committee Luncheons		120.72
Travelling Expenses		572.07
Entertainment		57.75
Review Illustrations		118.86
Bond on Treasurer		5.00
Gold Medal		62.00
Subscriptions		5.00
Servicing Typewriters		35.95
Light		52.63
Bank Charges		6.98
Transcription of Records		13.00
Complimentary Members, C.M.A.—3 at $4.00		12.00
Annual Meeting, 1951		52.50
Miscellaneous		89.19
		$14,579.08
Excess of Revenue over Expenditure for the period		10,415.42
		$24,994.50

32.

Estimated Cost of Operation From August 31st to December 31st, 1952

EXPENDITURE

Salaries	$ 4,240.00
Rent	559.20
Unemployment Insurance	25.00
Telephone	125.00
Light	25.00
Printing, Postage and Stationery	100.00
Miscellaneous Expenses	150.00
Annual Meeting	400.00
	$ 5,624.20

REVENUE

College of Physicians and Surgeons	$ 775.00
Winnipeg Medical Society	300.00
Bond Interest	172.50
	$ 1,447.50
Estimated deficit for period	$ 4,176.70
Excess of Revenue over Expenditure January 1st to August 31st, 1952	$10,415.42
Less estimated Deficit for period August 31st to December 31st, 1952	$ 4,176.70
Estimated profit for year 1952	$ 6,238.72

33.

As was reported to you in last year's financial statement, an anticipated increase of $2.00 per member, from $8.00 to $10.00, was paid to the national office as of January 1st, 1952. The increase in our Divisional membership fee for 1952, you will note, has increased our revenue considerably, making it possible to balance our budget and also to operate with an estimated surplus for the year of approximately $6,200.00. However, as was anticipated, with the many demands on its purse strings from various sources, the Canadian Medical Association at its Annual Meeting in June last passed a resolution to double its fee collectible from the Divisions and, as of January 1st, 1953, instead of paying $10.00 to the parent organization, we will pay $20.00, which will leave us with only $5.00 instead of $15.00 from $25.00 fee, and $30.00 instead of $40.00 from the $50.00 fee with which to operate in the coming year. With a membership of approximately 700, this increase of $10.00 to the C.M.A. will add an additional $7,000.00 to our expenses in 1953, which will wipe out the estimated surplus we will have at the end of 1952.

All of which is respectfully submitted.

Addendum: Motion adopted by Executive Committee, Oct. 6, 1952: THAT the Membership Fee of Manitoba Division be increased by $10.00, (from $50.00 to $60.00) for those members in active practice who may deduct dues for income tax purposes; all others to remain as at present, viz: $25.00.

Ruvin Lyons,
Honorary Treasurer

Economics

To the President and Executive of The Manitoba Medical Association:

34.

During the past year the Committee on Economics, as a committee, had little to do. However, the members of this committee were assigned to other committees and separate reports will be received from these committees. One member, for example, is on the Board of Trustees, Manitoba Medical

Service, and another is on the Fee Committee, as an ex officio member.

35.

The negotiations concerning Coroners' Fees, which were commenced last year, have been continued. Changes, which appeared to be satisfactory, have been made in fees to Coroners, Gaol Doctors, and for Autopsies. On good authority, we are assured that other changes are to be made as soon as they can be brought before the Cabinet Council.

Addendum: Since the writing of this report, your Chairman has been in contact with the Provincial Coroner and other Coroners and finds that the changes promised have not as yet been consented to. Negotiations will be carried on and it is hoped a better report will be made to next Annual Meeting.

36.

The Fee Committee has had a very busy year with two almost continuous projects on hand. First, there are the ever-changing fees that apply to Manitoba Medical Service, and, secondly, the committee is just completing a new Minimum Schedule of Fees for the Manitoba Medical Association. To you who have ever laboured with fees, this will indicate a great deal of tedious committee work.

It has been suggested that the Fee Committee should consider spending a whole day after the Annual Meeting and endeavour to set fees for the year at that time. The members of the Association, of course, would have to understand that their queries and requests for changes would not be studied until this one meeting takes place.

37.

The Workmen's Compensation Board Negotiating Committee had a very trying time this year. We are pleased to be able to report that real progress was finally attained and will be reported elsewhere.

38.

The report of the Manitoba Medical Service will reveal further gains. This committee has no direct relationship with the Board of Trustees, M.M.S., but we would like here to reiterate our confidence in the Board. We would also urge the members of the Association to give M.M.S. their support, for it seems to us that some form of socialized medicine is overtaking us and, with M.M.S. as the weapon, we feel we have a real argument to assure the profession a leading position in the management of any plan that is forthcoming.

39.

During the year the matter of reports to Insurance Companies came up again. Two points were raised: The first dealt with permission from the patient, and the second, payment of what is called a "Secretarial Fee." Your committee feels that the patient's permission in writing should be obtained. It also feels that the Insurance Companies should pay the fee because the practise of asking the doctor to give this report without fee, or to collect it from the patient, creates ill feeling all round. Our suggestion is that a small committee be appointed by the incoming Executive Committee with instructions to study this, to meet, if possible, the Insurance Underwriters, and to come to some understanding with them.

All of which is respectfully submitted.

Elinor F. E. Black,
Ruvin Lyons,
D. L. Scott,
Chairman.

Workmen's Compensation Board Medical (Referee) Committee

To the President and Executive of
The Manitoba Medical Association:

40.

For the year August 31st, 1951, to August 31st, 1952, your Committee held 16 meetings, when a total of 34 patients (also 1 from Sask.) were studied and reported upon.

No unusual difficulties were encountered.

Respectfully submitted.

C. E. Corrigan,
Chairman.

Membership

To the President and Executive of
The Manitoba Medical Association:

41.

I wish to present the following report to date.

There are 818 doctors in the Province of Manitoba,
565 Winnipeg
253 Rural

693	Active Paid-up Members	479 Winnipeg 214 Rural
7	Senior Members	4 Winnipeg 3 Rural
2	Complimentary Members, Armed Services outside of Canada	1 Winnipeg 1 Rural
3	Complimentary Members, due to Ill Health	2 Winnipeg 1 Rural
39	Retired or over 70 years	32 Winnipeg 7 Rural
96	Membership Fees Unpaid	64 Winnipeg 32 Rural
840		
22	paid fees who have since left province, or are deceased.	
818		

42.

Of the 96 doctors whose fees are unpaid, 20 are new registrants, 18 are interning in hospitals, 12 are in the Armed Services, 8 are not practising, leaving a potential 38 from whom fees are collectible. On this basis, the percentage of paid-up membership is 95.3, the highest ever achieved.

70 doctors have been lost to us during the year; 18 are deceased and 52 have left the province.

64 new members have been enrolled to date this year.

The number of paid-up members is higher by 10 than it was at this time last year. The total membership at the end of 1951 was 696, and there is every reason to expect that this figure will be exceeded before December 31st, 1952.

The above report is most gratifying to your committee, as indeed it must be to every member of the Association.

It is once more my pleasant duty and privilege to thank all members, as it is due only to your loyal support and co-operation that such a splendid report is made possible.

Respectfully submitted.

Addendum: Chairman reported since printing of report 12 additional fees have been paid, making total membership to date 705.

Ruvin Lyons,
Chairman.

Workmen's Compensation Board Negotiating Committee

To the President and Executive of
The Manitoba Medical Association:

43.

The Workmen's Compensation Board Negotiating Committee of the Manitoba Medical Association was originally composed of the following members:

Doctors:

C. M. Thomas, Portage la Prairie.
C. B. Schoemperlen, Winnipeg.
C. H. A. Walton, Winnipeg.
R. W. Richardson, Winnipeg.
P. H. McNulty, Chairman, Winnipeg.

In 1952 three additional members were added, in an ex officio capacity:

Doctors:

A. M. Goodwin, President.
D. L. Scott, Chairman, Committee on Economics, to replace Dr. R. W. Richardson.
F. G. Stuart, Honorary Secretary.

44.

Your Committee has been in close contact with Commissioner G. L. Cousley, Q.C., of the Workmen's Compensation Board, more or less continuously since February 24th, 1951. All of you were sent a summary in booklet form, outlining the details of our negotiations up to January 31, 1952. About this date it appeared that further deliberations would break down. Such an occurrence would have been very unfortunate, and certainly was not the wish of Mr. Cousley and his Board, nor of your Negotiating Committee. Following this stalemate, several letters passed between the Manitoba Medical Association and the Workmen's Compensation Board, the first under date of March 12, 1952, from Commissioner Cousley to Dr. M. T. Macfarland; Dr. Macfarland's reply under date of April 4, 1952. Under date of April 10, 1952, Commissioner Cousley wrote Dr. Macfarland advising that the Board was writing all members of the Association and, accordingly, under date of April 14, 1952, a general letter was sent from the W.C.B. to each member of the M.M.A., enclosing a Temporary Fee Schedule. Under date of April 29, 1952, a letter went out from President Goodwin to each member of the M.M.A., asking that you show your support of your Negotiating Committee by completing the enclosure cards, one to be returned to the Association, and one to be forwarded to Mr. Cousley, requesting him to deal directly with the Association and not with individual members. The response to this appeal was very gratifying indeed.

45.

On instructions from the Executive of the M.M.A. your Chairman met privately with Commissioner Cousley on two occasions during the past month, and on August 22nd, 1952, the final meeting resulted in the new Fee Schedule which has now been approved.

46.

As Chairman of the Negotiating Committee I wish to state that at no time have I received such courteous consideration as during these meetings, and when it came down to plain talking and straight dealing there were no difficulties or misunderstandings whatsoever. Mr. Cousley and his Board have given us the best Workmen's Compensation Board Fee Schedule in Canada. May I take this opportunity to thank Mr. Cousley for his kindness, sympathy and co-operation throughout the entire proceedings.

47.

I am proud to be Chairman of the Committee whose negotiations resulted in such a satisfactory fee schedule, and wish to express my personal thanks to the members of the Negotiating Committee for their time, their interest, loyalty and hard work. On behalf of the Committee, may I extend sincere thanks to the members of the M.M.A. Executive for their interest and complete co-operation at all times; and to the entire Association for the confidence and faith which was shown to us on every side.

Respectfully submitted.

P. H. McNulty,
Chairman.

Historical Medicine and Necrology

To the President and Executive of
The Manitoba Medical Association:

"and why should man fear death
seeing that death, a necessary end,
will come when it will come?"

48.

During the last year a number of our colleagues have passed from among us to their reward at the hands of the "Great Physician Himself." They have upheld the fine traditions of a profession which is still engaged in the battle for Life; and were they here to speak for themselves, not one of them would ask for pre-eminence in this tribute. Today we bid them "Hail and Farewell!"

Surely it behooves us who remain to carry on their work to give grave and serious consideration to the maintenance of those fine principles which have been so well and truly maintained by these, our brothers, who have passed to their reward:

Percy George Bell, Edgar Alexander Campbell, Thomas Hughes Cuddy, Oswald John Day, Clifford Rogers Gilmour, Howard Harvey, Hans Herschman, Richard Wellington Kenny, Oscar Margolese, Gerald Michael Olin, Baldur Haroldson Olson, Robert Rennie Swan, David R. Williams, Alexander Robert Winram; all of Winnipeg;

George Perry Armstrong, Portage la Prairie; Walter Henry Gabriel Gibbs, Selkirk; William Alexander Howden, Neepawa; Robert Kippen, Newdale; Henry Oliver McDiarmid, Brandon; Francis Sedziak, Elie; John Smith Stewart, Newdale.

Respectfully submitted.

Athol R. Gordon.
Chairman.

Editorial

To the President and Executive of
The Manitoba Medical Association:

49.

On the whole the Review has had a fairly successful year, but we still fall short of our goal which is to reflect all the important medical events in the Province.

We find it impossible to persuade the hospitals to help us in reporting their presentations. These are so varied and useful that they deserve the much wider audience of the Review. Last year Dr. M. H. Lehmann and Dr. Eric Gubbay were good enough to supply us with some items but the coverage should be, as far as possible, complete, and that requires active co-operation on the part of the hospitals.

Last year Dr. Murray Campbell reported on some of the meetings of the Winnipeg Medical Society. The papers given there should be a principal source of material. Again, our larger audience should be given the opportunity to read what only a few have had the opportunity to hear; and those who have heard would appreciate a permanent record from which they could refresh their memories and to which they could refer. Inasmuch as one remembers only a tenth of what he hears it is to the advantage of listener and speaker alike to have the matter set in print.

50.

We have been able to include a larger than usual number of Convention papers in the present volume. This is due to the fact that we recorded all the presentations. In future we do not mean to do this for local speakers but only for visitors unless the local speakers are willing to pay the cost involved.

More addresses would have been published had it not been that several of them were chiefly comments on many slides. It would have been impossible to reproduce these slides and without them the talks would have been largely pointless.

Generally speaking, local doctors are reluctant to write. Yet many speak often and could, without difficulty, put their words in writing. The College Faculty is so large that if each teacher were to contribute a single article every second year, there would be in each of our numbers three or more contributions in medicine, the same in surgery and a lesser number in the specialties; so slight would be the effort required that it would be no effort, yet is it not made. Again, if each interne were to contribute one case report during his year of service, there would be five of these to pick from every month. As it is there are none.

51.

The number of contributions at Ward Rounds, Luncheons, Sectional Meetings, etc., must be very large but we get none of them. Nor do we often get more than an announcement about topics of distinguished visitors.

If the individual members of the Association would realize how possible it is to give our readers—here and elsewhere—a useful post-graduate course they might be more inclined to

send us material; or if they would realize that in the Review we lay before strangers as well as before our friends, a record of our industry and achievements, they might take pleasure in increasing its usefulness, and pride in widening its scope; for by it, in large measure, we are judged by those who do not know us for it is our advertisement.

The Review can be greatly improved but only if those who can—and, indeed, should—help, are willing to do so.

52.

The Committee is deeply grateful to the Executive for the interest they take in our work. Lately they have set aside a sum of money for the payment of illustrations so that now we can furnish a limited number to contributors.

We are also greatly indebted to Mr. Whitley. Only those in closest contact with him realize how much he does, how well he does it and how much we owe to him.

We are grateful to those who have contributed papers and to those who have supplied material—Dr. M. H. Lehmann, Dr. Eric Gubbay, Dr. Murray Campbell, Dr. Ruvin Lyons, Dr. Paul Green, and Dr. Macfarland, who has found time, in spite of his pressing duties, to keep you excellently informed about the business of the Association.

53.

Personally, I must thank my never-failing associates, Dr. Peikoff and Dr. Ruvin Lyons, who have taken so much interest in the Review and who have given to it so much of their time (and—in the matter of illustrations—of their money). All her readers will agree that Dr. Borthwick-Leslie's sacrifice of time (spent partly in gossiping and snooping) is so well spent that without her we would be lost in a social sense. Dr. Ross Mitchell who, for many years, has faithfully performed the melancholy service of recording the deaths of our former colleagues has found it impossible to continue to do so. We are grateful to him for what he has done in the past. Unfortunately, so far, no successor in this task has been found.

We should all appreciate the interest of the advertisers who make the Review possible; and it is only proper that we should, whenever possible, favour those who favour us.

Lastly, the role played by Mr. Roscoe, the printer, should not be forgotten. There is no hint in the finished pages of the many technical difficulties which, each month, he has successfully overcome.

J. C. Hossack,
Chairman.

Manitoba Cancer Relief and Research Institute

To the President and Executive of
The Manitoba Medical Association:

54.

(The M.M.A. Representatives to the Cancer Relief and Research Institute constitute the Cancer Committee).

The Cancer Diagnostic Service Units set up by arrangement between the Manitoba Medical Association and the Manitoba Cancer Relief and Research Institute are now completing their second year of operation. These Units are situated in the Winnipeg General Hospital and the St. Boniface Hospital. Much of the work in the diagnosis and disposition of the patients seen in these diagnostic centres has been performed by recent medical graduates appointed by the Department of Surgery of the University on a half-time basis. In three out of four instances, the doctor employed is undertaking more extensive training as a surgical specialist. In their work in the Units, it is hoped that they will gain special experience in the field of cancer which will be of great value to them.

It appears, from available information, that rural physicians are employing the Units to an increasing degree. Thus the number of cases referred by them for the first nine months of this year slightly exceeds those of the first full year of operation. It may be estimated if the present rate continues, referrals during the second year will constitute a fifty per cent increase over the first year's total.

SUMMARY

December 1, 1950 to November 30, 1951		
Total Referrals	80	(W.G.H., 62) (St. Bon., 18)
Total Malignant	45	(or 56%)
Total Benign	33	(or 41%)
No definite diagnosis	2	
Total Referring Doctors	51	
December 1, 1951 to August 31, 1952		
Total Referrals	89	(W.G.H., 56) (St. Bon., 33)
Total Malignant	45	(or 51%)
Total Benign	43	(or 48%)
No definite diagnosis	1	
Total Referring Doctors	58	

Your Committee wishes to draw attention to the agreement between the Institute and the Association at the inception of the plan, viz., that the latter was to be initiated upon an experimental basis for a period of two years and be subject to review in the light of information gained at the end of one year. It is felt that it is now timely to undertake such a review.

Respectfully submitted.

Elinor F. E. Black,
Ruvin Lyons,
K. R. Trueman,
Chairman.

Editorial Board, C.M.A. Journal

To the President and Executive of
The Manitoba Medical Association:

55.

Your Editorial Board, Canadian Medical Association Journal, begs to report as follows:

Manitoba contributors to our national medical journal, which continues to maintain its high standard, during the past year were: Doctors F. G. Allison, D. W. Penner, F. A. Macneil, A. C. Abbott, S. S. Berger, A. A. Klass, C. W. Clark, J. R. Mitchell, A. A. Earn, B. H. Lyons and Ross Mitchell.

Respectfully submitted.

Athol R. Gordon,
Ross Mitchell,
Joint Chairmen

Maternal Welfare

To the President and Executive of
The Manitoba Medical Association:

56.

Your committee wishes to report as follows for the year 1951:

The maternal death rate was 1.09 per 1,000 live births (there were 20,127 live births in 1951). The figures for the previous 6 years were:

1945—1.9 per 1,000 live births
1946—1.7 per 1,000 live births
1947—1.1 per 1,000 live births
1948—1.4 per 1,000 live births
1949—1.3 per 1,000 live births
1950— .98 per 1,000 live births

The causes of death were as follows:

1. Abortions (induced) 6
   Autopsies were performed on all cases.
   5 not married
   2 Septic
   2 Air Embolism
   1 Haemorrhage
   1 Uraemia

2. Toxaemias 4
   Only 1 autopsy was done.
   3 primiparas
   2 had no prenatal care.
3. Haemorrhage 4
   Only 1 autopsy was done.
   1. Postpartum Haemorrhage. Indian, died at home.
   2. Placenta Praevia. Indian, died at home.
   3. Abruptio Placenta—Convelaire uterus. Died 8 hours after caesarean section—Town hospital. Received 1500 cc of blood and 500 cc plasma.
   4. Placenta Praevia—Died 4 hours after vaginal delivery —City hospital. Received 4000 cc of blood.
4. Accidents of Labor 4
   1. Induction of labor at 32 weeks. Died 6 hours after delivery of stillborn baby. Pulmonary embolism—No autopsy.
   2. Induction of labor. Had 1 previous caesarean section for placenta praevia. Ruptured uterus. Autopsy done.
   3. Haemorrhage, abruptio placenta, at term. 11 hours in labor. Manual dilatation and podalic version. Died 10 minutes after delivery—No autopsy.
   4. Manual rotation of left occiput transverse. Mid-forceps — Some disproportion — Haemorrhage. Later repair of cervix—Later hysterectomy. No autopsy.
5. Infection 1
   Manual removal of placenta for post-partum haemorrhage. Died 2 months later. Multiple septic infarcts—Subphrenic abscesses. Cerebral air embolism. Autopsy was performed.
6. Other causes 3
   No autopsy done.
   1. Indian—Para. 9. Died at home before delivery. Cause unknown.
   2. Indian—Died at home. Cardiac failure some time after delivery.
   3. T.B. Meningitis. Primipara. Died 3 months after delivery.

57.

This report is based on the information obtained from the 22 case records supplied by the Division of Statistics, Department of Health and Public Welfare.

The outstanding feature is the increasing number of criminal abortions which constitute 27.2% of maternal deaths and over which we have no control.

Autopsies were performed on 10 cases, 6 of which were abortions. On the other 16 maternal deaths only 4 autopsies were done.

It is the opinion of your committee that the classification of maternal deaths cannot be done satisfactorily without complete reports from the attending physician and the pathologist. We, therefore, urge all physicians associated with maternal death cases to answer all the questions in Department's inquiry form and to endeavor to obtain permission for autopsy.

We also recommend that a copy of the pathologist's report be sent to the Division of Statistics.

All of which is respectfully submitted.

H. Guyot,
Chairman.

Medical Education

To the President and Executive of
The Manitoba Medical Association:

58.

The Committee on Education had one meeting which took place on January 25th, 1952. The purpose of the meeting was to discuss certain proposals put forward by the Nucleus of the Committee on Education of the Canadian Medical Association. These were as follows:

1. International Conference on Medical Education:

Under the auspices of the World Health Organization and UNESCO, a conference on Medical Education was being planned to take place in London, England, in the autumn of 1953. The Committee was unanimously in favour of the proposal that such a meeting should be convened. Certain suggestions were made as to the programme and the contributors, which were submitted to the Chairman of tht Nucleus Committee on Education.

2. The Accrediting of Schools of Physiotherapy in Canada:

The Committee felt that a school of Physiotherapy was very much needed in Manitoba as one means of overcoming the chronic shortage of trained personnel.

3. Standardization of Awarding Degrees in Faculties of Medicine in Canada:

The Committee was in agreement on the principle of establishing a uniform time for the awarding of degrees of Doctor of Medicine by the various universities in Canada. It was felt, however, that there should be control by the university of the interning year. A year's interneship should be obligatory before the granting of a license by the College of Physicians and Surgeons, and such hospitals should be given strict scrutiny by the Colleges.

4. Careers Open to Medical Graduates:

It is recommended that a plan be made for the organized guidance of undergraduate students in the planning for their future careers. This suggestion was submitted to the Executive Committee and was approved.

5. Radio Talks:

The Talks Department of the Canadian Broadcasting Corporation have made a suggestion that a series of talks on medical subjects for the layman be given over the local station CBW and perhaps over the Prairie Regional Network. This proposal was submitted to the Executive Committee and was approved. The details are now being worked out, and, as matters stand at present, the talks will probably start during the autumn of 1952.

Respectfully submitted.

Louis Cherniack,
Chairman.

Public Health

To the President and Executive of
The Manitoba Medical Association:

59.

The following is a report of the activities for the year 1952 of your committee:

In January the question of the advisability of the Fluoridation of Water for the City of Winnipeg was studied at the request of the Winnipeg Dental Society. Your committee recommended endorsation of the principle of the Fluoridation of Water and its decision was passed by Executive Committee.

In the summer a report of the Public Health Committee of the Canadian Medical Association was received.

Also, your Chairman was included in a committee with Dr. Dwight Parkinson and Dr. Murray H. Campbell of the Committee of Fifteen, to study a proposed amendment to the Public Health Act, making (1) Epilepsy, (2) Visual Field Defects, (3) Lesions of the Central Nervous System which impair movement or co-ordination, or judgment—reportable diseases. These people are thought by some to be a distinct menace to the public while driving a car. This amendment would throw the onus of allowing these people to drive on the Highway Traffic Department. Your Public Health Committee was in favour of this action and, if it meets with the approval of the profession, it may be brought before the Legislature in the near future.

Respectfully submitted.

Addendum: Motion adopted by Executive Committee, Oct. 6, 1952: THAT the last sentence of this report be not recommended by Executive Committee.

R. W. Whetter,
Chairman.

Post Graduate Studies

To the President and Executive of
The Manitoba Medical Association:

60.

A Refresher Course was conducted by the Faculty of Medicine of the University of Manitoba with the assistance of the Manitoba Medical Association, Winnipeg Medical Society, and the Department of Public Health, during the week of April 14th, 1952.

The guest speakers were:

Dr. A. W. Farmer, Department of Surgery, University of Toronto.

Mr. W. P. Fillmore, Q.C.

Dr. Chester M. Jones, Clinical Professor of Medicine, Harvard University.

Dr. R. R. Kierland, Section of Dermatology, Mayo Clinic.

Dr. Edwin M. Robertson, Professor of Obstetrics and Gynaecology, Queen's University.

Honorable Ivan Schultz, Q.C., Minister of Health and Public Welfare.

A questionnaire was sent to those who attended the course and the returns would indicate that they were very satisfied; they made a few constructive suggestions for next year.

A tentative date for next year's course was fixed for the week of April 13th.

All of which is respectfully submitted.

L. A. Sigurdson,
Representative.

Extra Mural

To the President and Executive of
The Manitoba Medical Association:

61.

The following is an outline of the meetings held during the past year:

Brandon and District Medical Society:

November 14th, 1951, at Ninette:
- Dr. J. M. Kilgour—"Acute Glomerular Nephritis and Lower Nephron Sclerosis."
- Dr. H. S. Evans, F. J. E. Purdie, S. Witt and R. F. M. Myers—Film and Discussion on: "Calcification of the Rotator Cuff of the Shoulder."
- Dr. A. L. Paine—"Advances in Surgical Removal of the Lung for Tuberculosis."

April 2nd, 1952, at Brandon:
- Dr. Ruvin Lyons—"Hormone Therapy in Gynaecology."
- Dr. J. D. Adamson—"Present Inadequate Treatment for Arthritis and outlined work done by Canadian Arthritis and Rheumatism Society."

May 21st, 1952, at Brandon:
- Dr. J. Hoogstraten, Dr. Sydney Israels—"Symposium on some Paediatric Problems."
- Dr. G. A. B. Cowan, Dr. A. H. Povah—"Account of recent Tuberculosis Survey results."

Central District Medical Society:

March 25th, 1952, at Portage la Prairie:
- Dr. Murray McLandress—"Diagnosis of Several Paediatric Conditions."
- Dr. Brian D. Best—"Hormonal Treatment in Gynaecology."

North of 53 District Medical Society:

March 19th, 1952, at Flin Flon:
- Dr. A. Gibson—"Low Back Pain."
- Dr. C. B. Stewart—"Traumatic Lesions of the Urinary Tract."

Northern District Medical Society:

November 15th, 1951, at Dauphin:
- Dr. A .C. Abbott—"Sympathectomy in the Treatment of Hypertension."
- Dr. P. T. Green—"Classification and Treatment of Anaemia."

March 18th, 1952, at Dauphin:
- Dr. A. Gibson—"Low Back Pain."
- Dr. C. B. Stewart—"Traumatic Lesions of the Urinary Tract."

May 7th, 1952, at Dauphin:
- Dr. A. B. Houston—"Dyspepsia—Its Clinical Valuation."
- Dr. Dwight Parkinson—"Diagnosis of Brain Tumors."

Northwestern District Medical Society:
(Combined Meeting of Brandon, Northern and Northwestern Districts)

June 25th, 1952, at Clear Lake:
- Dr. C. E. Corrigan—"Incisions," illustrated by lantern slides."
- Dr. R. M. Ramsay—"Common Ophthalmological Conditions."
- Mr. Bruce Bracken—Film on "Glaucoma," produced by the National Film Board.
- Dr. William Gardner—After-dinner speaker.

Southern District Medical Society:

September 20th, 1951, at Altona:
- Dr. J. L. Beckstead—"Causation Factors in Chest Disease."
- Dr. K. C. McGibbon—"Orthopaedic Problems in the Young."

May 15th, 1952, at Morris:
- Dr. H. Medovy—"Common Paediatric Problems."
- Dr. R. M. Ramsay—"Common Ophthalmic Problems."

The Societies are to be congratulated on their efforts to continue periodic meetings. If it were possible to arrange for the meetings to be held in rotation at stated intervals the duties of this committee in arranging for speakers would be facilitated.

Respectfully submitted.

D. S. McEwen,
Chairman.

Public Relations

To the President and Executive of
The Manitboa Medical Association:

62.

There have been a few problems that the committee has had to attend to during the past year. The charge was made by one of the members in the Legislature that doctors were charging exorbitant fees. Investigation by your committee proved that the charges made against the profession were groundless.

The newspaper coverage for our convention last year was not as great as we would have liked, the reason being that our convention week coincided with the visit of Princess Elizabeth. The newspaper coverage was also small at the time of the Post-Graduate Courses meeting in April, due to the fact that the papers were greatly concerned with the Power Project Referendum at the time. In spite of these disappointments, your Association has harmonious relations with the Press.

All of which is respectfully submitted.

L. A. Sigurdson,
Chairman.

Liaison - M. M. A. - C. P. & S.

To the President and Executive of
The Manitoba Medical Association:

63.

Two meetings of this Committee were held, one prior to and one following alterations to increase available office space and improve facilities. A satisfactory working agreement is in effect at the present time.

Respectfully submitted.

A. M. Goodwin,
Chairman.

Fee

To the President and Executive of
The Manitoba Medical Association:

64.

Since the last Annual Meeting of the Association there have been seven meetings of the Fee Committee attended by four ex-officio members in addition to the three regular members.

Schedule of Minimum Fees, Manitoba Medical Association:

During the year progress was made in revision of the Minimum Schedule of Fees as requested by the Executive Committee in 1951. Fees submitted by groups or sections were incorporated into the Schedule, and it was agreed that other submissions made prior to December 31st, 1952, would be considered by the Committee before being included in the Schedule.

Manitoba Medical Service Tariff:

Progress in arranging fees for use of Manitoba Medical Service is reported. Before the resolutions of the last Annual Meeting were acted upon, many changes were notified by the Manitoba Medical Service to the medical members in a circular dated November 1st, 1951. Representatives of groups appeared before the Committee and assisted in the discussion of fees which should be recommended to Manitoba Medical Service. When it became known that the General Practitioners' Association would submit a complete schedule of fees which it desired to have incorporated into the Manitoba Medical Service Tariff, irrespective of fees allowed to other Practitioners, the need for the committee provided by the last Annual Meeting was not apparent. Additional changes were outlined by the Manitoba Medical Service to medical members on February 1st and July 11th, 1952.

The Committee again considered the suggestion that when the fee tariff policy has been decided by the Annual Meeting the Fee Committee should sit for one or two days to hear representations from individuals, groups, or sections, following which further numerous changes should not be made for the period of one year. Manitoba Medical Service would know that the fee tariff structure would remain constant, except for necessary minor alterations, and frequent tedious meetings of the Fee Committee would be avoided.

Respectfully submitted.

A. M. Goodwin,
Chairman.

Group Insurance

To the President and Executive of
The Manitoba Medical Association:

65.

Three hundred and fifty-one members of the Manitoba Medical Association are policy holders in the Group Accident and Sickness Insurance Plan sponsored by the Association. Since there are six hundred and eighty-nine paid-up members of the Association, this is slightly more than 50% of the total membership. There were twenty-five new policies issued during the past year but, taking into account death and lapses, there has only been a net gain of two new policy holders over the number for 1951.

Twenty-two thousand dollars has been paid out during 1952 in claims. This does not include claims being processed at present nor the balance of payments still to be made on claims which have been accepted.

Difficulties with claims do not usually come to the attention of the Group Insurance Committee but enquiry has shown that there has been a minimum of difficulty in obtaining approval and payment for claims.

There have been several discussions by members of the Manitoba Medical Association with the undersigned regarding other policies which have been offered to specialized medical groups and also to individuals. When these have been studied, it has always appeared that the present plan initiated by the Association is equal and, in many cases, superior to any other plan which has been broached.

The continuation of the Group Accident and Sickness Insurance Plan for the members of this Association is again endorsed.

Respectfully submitted.

L. R. Rabson,
Chairman.

Pension

To the President and Executive of
The Manitoba Medical Association:

66.

In last year's report we mentioned that no provision for pension deductions for self-employed were contemplated by the Federal Government. During the year your Executive Secretary, Dr. M. T. Macfarland, and myself approached the Liberal Association of Manitoba with the proposal that they recommend and approve income tax deductions for pensions of the self-employed. This, both the committee and the representative of Winnipeg South, Mr. Leslie Mutch, sidestepped as per attached correspondence:

January 22nd, 1952.

Mr. L. A. Mutch, M.P.,
Room 413,
Fort Garry Hotel,
Winnipeg.

Dear Mr. Mutch:

The present Income Tax Act makes no provision for pension deductions by self-employed persons.

This matter has previously been discussed with the Minister of National Revenue and the Minister of Finance by representatives of the Canadian Medical Association.

Attention was drawn that self-employed taxpayers have not been afforded the same treatment as have subscribers to approved pension plans.

It was urged that such taxpayers be permitted to deduct up to $900.00 per year expended on the instalment purchase of annuities, or contributions to other retirement plans recognized by Government.

It is respectfully requested that appropriate action be taken to provide income tax relief for contributions to retirement funds.

Your interest and support will be appreciated.

Yours very truly,
M. T. MACFARLAND, M.D.,
Executive Secretary.
Ottawa, Ontario,

March 12th, 1952.

Dr. M. T. Macfarland,
Executive Secretary,
Manitoba Medical Association,
604 Medical Art Building,
Winnipeg, Manitoba.

Dear Doctor Macfarland:

Following our conversation in the hotel, the subject of it was raised in the Convention but was not debated on the floor.

It has been brought to Mr. Abbott's attention and on April 8th we shall see if we have succeeded. If not, we shall try again.

Yours sincerely,
L. A. MUTCH, M.P.,
Parliamentary Assistant.

67.

The Lawyers of Canada are also interested in having the income tax law amended so that pension funds for self-employed be deductible from income tax. Your income tax committee proposes to work with the lawyers' organization, if

this meets with your approval. As we are aware, the income tax rate has become prohibitive in Canada. This does not prevent the Minister of Finance from seeking other sources for income, and your committee would not be surprised if tax-free pension deductions were cancelled. In other words, they are thinking seriously of disallowing deductions for annuities for those who are now employed by corporations. If this is carried out, the self-employed will have no case.

In view of the above, this committee, through the Manitoba Medical Association, would urge its members to take out the maximum Dominion Government annuity of $100.00 monthly if they have not done so. The doctor should pay the first monthly premium in order to protect the interest rate earned by the Dominion Government annuities, but to save through some other form of investment and convert these savings, on the doctor's retirement, to cash and pay up their government annuities.

68.

The reason for the above recommendation is that the present rate of bank and bond interest is in the ascendancy and will, no doubt, be increased in the near future. If this is so, the government rate of interest guaranteed on annuities will also have to be increased, so that by investing the premiums in stocks or bonds paying more than the guaranteed rate, by the time the annuity is due, the cash so accrued will represent both the dividends earned and the appreciation on the investment.

By purchasing the Dominion Government annuities at the present with the payment of only the first dividend, this will establish a firm contract with the Dominion Government to pay the purchaser the $100 annuity at the due date when he pays the sum required by the contract on the annuity. In other words, by payment of the first premium on the government annuity, you will have purchased the right to call on the government to deliver to you the annuity based on 4% return on the monies invested up to the age of 65. Should the government annuity rate diminish from 4%, you have the above protection. Should it increase over 4% the monies you will put in will accrue in the form of an annuity at the new greater rate of interest.

69.

The advantage of a government annuity over one issued by the insurance companies is that the administrative costs are borne by the Federal Government so that the difference between the costs of the two annuities is illustrated in the following:

Males to retire at 65

Annual Premium for each $10 of monthly pension guaranteed 10 year and life thereafter

Age	Govt. Annuity	Inurance Co. Annuity
30	$21.40	$26.83
35	27.62	33.64
40	36.62	43.58
45	50.44	58.75

The advantages between the government and the insurance companies annuities can all be overocme by not paying the premium until the annuity is required. In other words, you do not lose control of your money if you will follow the investment policy that the insurance companies follow:

70.

1. If the annuity income is to commence immediately or within a short period of time and where all contingencies can be properly weighed—Government annuities should be used for the first $100 of monthly income. The cost discrepancy is too greatly in favour of the Government Annuity. This does not mean that the Company rate is too high, but simply that Government Annuities are subsidized and partly paid through taxation.

2. If, as happens in some cases, a person has a substantial sum of surplus capital which he is unlikely to require, then a Single Premium Deferred Annuity may be purchased from the Government to provide a Deferred Annuity Income up to $100 per month. The capital will be irrevocably frozen but it is probably the best tax-free investment in Canada today under our present laws.

3. We advocate, as a buy for nearly everyone, monthly Premium Deferred Government Annuities to be used in the following manner. Determine the amount of annuity income up to your $100 monthly you need at retirement. Buy it on a monthly or quarterly premium basis and pay the first monthly or quarterly premium. You then get your contract under present regulations with this first monthly or quarterly premium. You are not required to disclose your intent. If you have any windfalls that you won't require you can plough these into your Government Annuity. If you haven't and the time comes when you want to retire, you can liquidate such of your other assets, including insurance, that you do not require and pay up your Government Annuity at your protected rate, together with interest. You will then have a flexible plan which meets every requirement of any long-range plan.

71.

As for the investment in common stocks, obtain a list from your broker of the securities that are deemed eligible for investment by the Canadian Life Insurance Company. In making your selections, observe the following rules:

1. Do not let anyone select your securities for you.
2. Study the securities before you buy them.
3. Only buy securities that you know and understand and that pay a dividend of 4% or more.

The above plan may also be applicable to your wife or other dependents.

Respectfully submitted.

M. S. Hollenberg,
Chairman.

Section on Internal Medicine

To the President and Executive of
The Manitoba Medical Association:

72.

During the year 1951-52 the Section held three meetings, at which the following papers were presented:

Dr. Ashley E. Thomson	Diurnal Variations in Electrolyte Excretion
Dr. A. B. Houston	Auricular Fibullation and Blood Quinidine Levels
Dr. N. Blanchaer	Some Problems in Blood Storage
Dr. J. B. Armstrong	The Use of Blood Substitutes.
Dr. M. Ferguson	Pancreatic Excretion of Electrolytes
Dr. J. D. Adamson	Servetus

The Section has expressed its feeling that scientific papers presented at meetings should be reported to the Manitoba Medical Review whenever possible.

At a meeting held on the 20th of March, 1952, it was moved by Dr. A. Hollenberg, seconded by Dr. C. B. Schoemperlen, that an annual fee of $2.00 be collected from all members of the Internist Section. The motion was adopted.

The following officers of the Section were elected for the year 1952-53:

Honorary President	Dr. J. D. Adamson
President	Dr. L. G. Bell
Vice-President	Dr. J. Doupe
Secretary-Treasurer	Dr. Ashley E. Thomson
Programme Committee	Doctors Murray H. Campbell, Sam D. Rusen, J. L. Beckstead

Respectfully submitted.

Eric R. Gubbay,
Secretary.

GLYCURRANT

For the Relief of Persistent Coughs

A combination of effective sedatives and expectorants in a delicious preparation of Black-currant juice.

GLYCURRANT overcomes the difficulty of allaying persistent cough without resorting to respiratory depressants in large doses. It combines stimulating expectorants and respiratory sedatives of established efficiency, skilfully combined to relieve the chest, in a vehicle specially designed to exert its soothing local action on the irritated structures of the throat.

EACH FLUID OUNCE CONTAINS

Codeine Phosphate	gr. ⅓	Menthol	gr. 1/20
Syrup Wild Cherry	min. 40	Tincture Squill	min. 40
Glycerin	min. 80	Tolu	min. 40
Black Currant Juice	min. 165	Alcohol	5 percent

Dosage: Adults 1 to 3 teaspoonfuls undiluted should be sipped slowly every 3 or 4 hours. The size of the dose and the frequency of administration are varied at the physician's discretion.

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General Practitioners' Association of Manitoba

To the President and Executive of
The Manitoba Medical Association:

73.

Monthly executive meetings were held throughout the year to deal with the business of the Section.

At a combined meeting of the Winnipeg Medical Society and the General Practitioners' Association, two addresses were heard, the speakers being Dr. H. Medovy and the Honourable Ivan Schultz, Q.C. The co-operation of the two societies was most cordial.

The General Practitioners have this year decided to submit to your Fee Tribunal a fee schedule for submission to the M.M.S., said schedule to apply under the block system of the M.M.S. We are pleased to report that our recommended Obstetrical Fee has already been implemented into the M.M.S. fee schedule; and express a wish that the recommended fee for house calls be approved shortly.

Some of the matters of concern and interest to our Section that have been discussed are:

1. The classification by Hospital Insurance Companies of "Pre existing Cases." With many of these decisions we are in disagreement.
2. The fact that the M.M.S. yet fails to pay 100%, less operating costs.
3. The Certification of General Practitioners.
4. The feasibility of affiliating with the American Academy of General Practice.
5. The need for Business Administration becoming a medical specialty.
6. The question, "Is State Medicine inevitable?"
7. Can the General Practitioner be compensated by the M.M.S. for time utilized in Psychosomatic Medical Care?
8. The lending of our support to the Section of General Practice of the Canadian Medical Association in their efforts to secure accreditation for General Practitioners in Teaching Hospitals.

A well attended Social evening was held at "Jack's Place."

The two scholarships were made an annual affair.

Membership in the Association is quite satisfactory and the Executive a choice, enthusiastic, constructively critical group.

Respectfully submitted.

J. F. Edward,
Secretary.

Medical Library Evening Hours

Sponsored by the Winnipeg Medical Society

The Library will be open from 8 p.m. to 10 p.m., Monday through Friday, from November 1st to December 19th, 1952, and from January 5th to April 30th, 1953.

Regulations

(1) The Library Committee wishes it understood that the Closing Hour of 10 p.m. will be STRICTLY ADHERED TO;

(2) All Reading Room facilities available to Physicians and Students;

(3) The Student on duty will assist in looking up subjects in the Quarterly Cumulative Index Medicus for the last ten years;

(4) If previous references are required they should be obtained during the regular library hours (9 a.m. to 5.30 p.m.).

(5) **The Stackrooms will NOT BE OPEN.**

The Medical Library Committee.

September 15, 1952.

"Lederle Assists University Department"

"The Department of Physiology and Medical Research recently received from Lederle Laboratories Division of the North American Cyanamid Limited material to bind one hundred volumes of the journals in the Department library. These journals are purchased with funds supplied by various non-University sources and supplement those stored in the Medical Library. However in view of the high cost Professor Doupe has declined to dissipate the funds for binding purposes. Therefore the Lederle gift, and the promise that the annual needs will be taken care of, constitute a very significant contribution to the teaching and research activities of the Department."

Department of Health and Public Welfare

Comparisons Communicable Diseases — Manitoba (Whites and Indians)

DISEASES	1952 Aug. 10 to Sept. 6,'52	1952 July 13 to Aug. 9,'52	1951 Aug. 12 to Sept. 8,'51	1951 July 15 to Aug. 11,'51	Total Jan. 1 to Sept. 6,'52	Total Jan. 1 to Sept. 8,'51
Anterior Poliomyelitis	159	132	12	3	301	19
Chickenpox	34	59	53	85	943	1196
Diphtheria	0	0	0	0	2	5
Diarrhoea and Enteritis, under 1 yr.	13	11	17	18	82	123
Diphtheria Carriers	0	0	0	0	0	1
Dysentery—Amoebic	0	0	0	0	0	0
Dysentery—Bacillary	1	0	1	8	14	24
Erysipelas	2	0	1	3	11	22
Encephalitis	2	0	0	0	3	2
Influenza	5	4	3	2	118	771
Measles	43	117	46	58	1110	2771
Measles—German	0	0	2	4	11	38
Meningococcal Meningitis	1	1	2	3	12	27
Mumps	72	62	38	45	1024	1093
Ophthalmia Neonatorum	0	0	1	0	1	2
Puerperal Fever	0	0	0	1	1	1
Scarlet Fever	13	34	73	62	508	960
Septic Sore Throat	4	3	2	4	67	21
Smallpox	0	0	0	0	0	0
Tetanus	0	0	1	0	3	1
Trachoma	0	0	0	0	0	0
Tuberculosis	81	64	71	57	561	770
Typhoid Fever	1	0	0	0	1	2
Typhoid Paratyphoid	0	2	0	0	2	0
Typhoid Carriers	0	0	0	0	0	0
Undulant Fever	0	1	1	2	3	9
Whooping Cough	25	138	37	45	342	332
Gonorrhoea	103	129	105	83	923	845
Syphilis	5	9	7	12	81	114
Infectious Jaundice	3	0	0	0	27	0
Tularemia	0	0	0	0	3	0

Four-Week Period August 10th to September 6th, 1952

DISEASES (White Cases Only) *Approximate population.	*776,541 Manitoba	*861,000 Saskatchewan	*3,825,000 Ontario	*2,952,000 Minnesota
Anterior Poliomyelitis	159	394	228	989
Chickenpox	34	56	208	....
Diarrhoea & Enteritis under 1 year	13	....	....	....
Diphtheria	....	....	....	2
Diphtheria Carriers	....	....	....	....
Dysentery—Amoebic	....	....	2	7
Dysentery—Bacillary	1	....	5	6
Encephalitis Epidemica	2	2	....	2
Erysipelas	2	2	1	....
Influenza	5	....	18	1
Infectious Jaundice	3	....	26	5
Measles	43	53	167	12
German Measles	....	4	17	....
Meningitis Meningococcus	1	4	6	4
Mumps	72	25	343	....
Ophthal Neonat.	....	....	....	....
Puerperal Fever	....	....	....	....
Scarlet Fever	13	29	23	9
Septic Sore Throat	4	3	3	4
Smallpox	....	....	....	....
Tetanus	....	....	....	....
Trachoma	....	....	....	....
Tularemia	....	....	....	3
Tuberculosis	81	23	63	174
Typhoid Fever	1	1	6	....
Typhoid Paratyphoid	....	....	....	6
Typhoid Carrier	....	....	....	....
Undulant Fever	....	1	3	....
Whooping Cough	25	43	130	5
Gonorrhoea	103	....	176	....
Syphilis	5	....	45	....
Malaria	....	....	....	2

DEATHS FROM REPORTABLE DISEASES

For the Month of August, 1952

Urban—Cancer, 47; Pneumonia Lobar (490), (491-493), 2; Pneumonia (other forms), 1; Poliomyelitis, 4; Tuberculosis, 7. Other deaths under 1 year, 23. Other deaths over 1 year, 196. Stillbirths, 22. Total, 241.

Rural—Cancer, 35; Influenza, 1; Measles, 1; Pneumonia Lobar (490), (491-493), 4; Pneumonia (other forms), 1; Poliomyetitis, 4; Tuberculosis, 4; Diarrhoea and Enteritis under 1 year, 2; Pneumonia of Newborn, 1. Other deaths under 1 year, 20; Other deaths over 1 year, 181; Stillbirths, 13. Total, 214.

Indians—Cancer, 1; Pneumonia (other forms), 1; Tuberculosis, 1. Other deaths under 1 year, 4. Other deaths over 1 year, 5. Stillbirths, 1. Total, 10.

♦

Anterior Poliomyelitis is the chief disease of interest at the time of writing (September 18th) with 403 cases reported causing 15 deaths. Bulbar cases have been common and the number of deaths in the age group twenty years and over is more than usual. All four western provinces have been hit hard—Manitoba least.

Typhoid Fever—One of our old bugbears shows one case reported by September 6th. This was a little girl from Grunthal. Since then we have had a girl from Portage la Prairie reported as a case and a young man from Rossburn Rural Municipality. These three cases seem to have no connection and are therefore a problem as to sources of infection.

Detailmen's Directory

Representing Review Advertisers in this issue, whose names are not listed under a business address.

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R. G. (Bud) Harman 592 648
D. A. Tedford 724 863

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